S. HRG. 103-500

SINGLE-PAYER HEALTH CARE SYSTEMS: ISSUES AND OPTIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON LABOR

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

ON

TO PROVIDE FOR A STATE ADMINISTERED SINGLE-PAYER HEALTH CARE SYSTEM IN THE UNITED STATES, FOCUSING ON ACCESS TO QUALITY HEALTH CARE AND COST CONTROL ISSUES

OCTOBER 19, 1993

Printed for the use of the Committee on Labor and Human Resources

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TUESDAY, OCTOBER 19, 1993

ADDITIONAL MATERIAL

SINGLE-PAYER HEALTH CARE SYSTEMS: ISSUES AND OPTIONS

TUESDAY, OCTOBER 19, 1993

U.S. SENATE,
SUBCOMMITTEE ON LABOR, OF THE COMMITTEE ON LABOR
AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:30 p.m., in room SD–430, Dirksen Senate Office Building, Senator Howard M. Metzenbaum (chairman of the subcommittee) presiding.

Present: Senators Metzenbaum, Harkin, Wellstone, and Jeffords.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM. The hearing will come to order. Good afternoon. Today, the subcommittee will hear testimony from American and Canadian doctors and health care experts who believe the United States would benefit by adopting a single-payer health care system.

We are at an historic moment in the United States. After almost a century of thwarted attempts at reform, the United States finally is on the verge of adopting a comprehensive health care system. Never before have we had a President and First Lady as committed to solving the riddle of how to provide affordable health care to every American.

I must say that never before have we had a President and First Lady, nor even a President alone, who knew as much about a subject that was before the Congress as the President and the First Lady do. They have truly, really involved themselves totally on this issue.

In many ways, the debate has already been won. An overwhelming majority of Americans support comprehensive health care reform and agree on the fundamental elements of reform. There is agreement that we need a universal system so that all Americans, young or old, rich or poor, healthy or sick, will have access to health care. We agree that everyone should be covered by an adequate level of health care benefits—hospital care, physician care, prevention, mental health benefits, prescription drugs, and long-term care. We agree that individuals should be able to choose their own doctors, and finally we agree that we must cut the fat out of our system and get our spending under control.

Now, the real debate, then, is how do we redesign our system to achieve these objectives. The majority of patients, providers, and health policy experts agree that a single-payer system is the ideal

system, but as a practical matter few people think we have the will power to take on the special interests who would lose out under such a system.

Quite simply, a single-payer system is the easiest and fairest type of health care system. All that single-payer means is that instead of 1,500 insurance companies, a single entity collects our health care dollars and directly pays health care providers. Under a single-payer system, Government raises the revenue either through income or payroll taxes, and providers of health care determine how these funds will be spent. Single-payer requires the least amount of Government bureaucracy, while providing doctors and patients with the maximum amount of free choice and flexibility.

What single-payer doesn't have is the middle man—no more insurance companies, no more claims reviewers. Nor is single-payer the system for multimillionaire doctors. Single-payer adequately compensates doctors and other providers, but it treats health care as a social good, not a capital good, so that individuals seeking profit cannot arbitrarily set the price of treating the sick.

The greatest obstacle to adopting a single-payer system has been the opposition of the organized medical profession. The American Medical Association historically has opposed any type of Government-sponsored system. Many doctors fear a large Government bureaucracy that would control their incomes and the way they practice medicine.

First, their fears are misplaced, as we will hear today. Single-payer systems need not be bureaucratic and, in fact, provide doctors with a high degree of flexibility and autonomy. Second, our current system has become a nightmare for doctors. Their lives are controlled by an endless number of insurance companies and other intermediaries. They must fill out endless paperwork. One doctor works in the office and has 2, 3 or 4 assistants helping him or her just doing the paperwork. Their decisions are overseen by an army of claims and utilization reviewers.

Growing numbers of doctors and other health care providers are starting to see the light. They realize we need to take back our health care system—take it back from the insurance companies and the big conglomerates. Whether the United States adopts a single-payer system or one more along the lines that President Clinton has proposed, we need to make it a system that allows providers to provide and patients to receive quality health care.

For the next year, each of the health care industry special interests will be fighting to maintain their piece of the pie. I hope providers and consumers will band together and stand up to the special interests and fight for a better health care system.

Now, there is one person in the Senate who has been like a charging bull and hit the road running when he came to the Senate on behalf of the single-payer system, my colleague from Minnesota. He has done a superb job in alerting many in the country, and it is only fair to say he has been very instrumental in causing this hearing to be brought about. I am very happy to have him here today and I am always pleased to work with him in the Senate, my friend, Paul Wellstone.

OPENING STATEMENT OF SENATOR WELLSTONE

Senator WELLSTONE. Thank you very much, Mr. Chairman. I will be very brief. Let me thank Senator Metzenbaum for chairing this hearing today, the Labor Subcommittee hearing of the Labor and Human Resources Committee, on the single-payer bill. I introduced this bill, the American Health Security Act, in 19992 and 1993, first with Congressman Russo and now with Congressman McDermott and Congressman Conyers, and both times with the strong support of Senator Metzenbaum.

I would thank everyone for being here today, too. We have such a really good turn-out of people. Thank you very much for your interest.

I introduced this legislation because people in Minnesota cafes over and over and over again would simply say, Senator, will health care reform provide good coverage for myself and my loved ones? Am I going to be covered? Will it be a decent package of benefits? Will I be able to choose a doctor and will I be able to afford it? I believe that the single-payer bill gives a resounding yes to all of those questions.

We are going to have some testimony today from doctors from Canada, and I so appreciate your being here because one of the real virtues of the single-payer plan is that unlike every single other proposal, the evidence is almost irreducible and irrefutable, Mr. Chairman, that we can save costs where you should save costs by applying the tourniquet where it should be applied. We go after the administrative bloat, and a conservative estimate is we can save about $100 billion a year just by doing that, money that can be used to cover those people without insurance and those people that are underinsured.

We also have, I think, very important testimony today from caregivers, including Dr. Frank Indihar from Minnesota, and they will speak about the doctor-patient relationship and they will emphasize, Mr. Chairman, the importance of caregivers being able to provide the kind of care to people that they imagined they would be able to provide when they were in medical school.

I think as we read the newspapers in the United States of America and we see this wave of corporate takeovers, this merger mania and large insurance companies and others moving in and taking over these networks either from doctors or from nurse practitioners and others. We will hear a tremendous amount of concern about being micro managed. One of the real great conservative virtues of the single-payer plan is we leave it up to individual people as to what kind of choice they want to make.

Finally, Mr. Chairman—and I would like for my full remarks to be included in the record.

Senator METZENBAUM. Without objection.

Senator WELLSTONE. I just want to mention that I just had a most interesting experience with the Citizens Jury that convened here last week in Washington, DC, 24 women and men chosen randomly by region, by race, by presidential preference in the last election. What was interesting to me, Mr. Chairman, and this builds on the remark that you just made, is that the people there had never been let in on the secret that the pattern of power in Wash-

ington had already decided that the single-payer plan should not be on the table.

They thought that in a democracy people in the country get to decide, and so they spent 5 days listening to testimony, and then what they decided on the basis of what they thought would be the best plan for people in the country, not what was acceptable to the insurance industry or the pharmaceutical industry, was that the President's proposal really needed to move in the single-payer direction.

I just simply want to emphasize to you the importance of this hearing today because I am convinced that the more people in the country have the opportunity to view the full range of alternatives, the more that we insist that that be the case, which is the test case of any representative democracy, the greater the chance will be that people in our Nation, when it comes to the final decision we make—and we must pass health care reform in the United States Congress—will be much closer to the standard we set with the single-payer bill.

I would like to thank each of the panelists for being here. Your testimony is very important and we really appreciate it.

[The prepared statement of Senator Wellstone follows:]

PREPARED STATEMENT OF SENATOR WELLSTONE

Senator Metzenbaum, I want to thank you as chair of the Labor Subcommittee for convening this hearing on the single payer health care system. I am proud to co-chair this hearing with you, as I am proud to share with you the distinction of cosponsoring the American Health Security Act, S. 491, the Senate proposal for single payer health care reform in the United States.

I introduced a single payer reform bill both in 1992 and in 1993, with your support on both occasions, Mr. Chair. I did so because I am convinced that it meets all the standards of the Minnesota cafe test. Cafes are where you meet the people of Minnesota, and every time I go back to Minnesota I hear the same questions about health care reform, and how we're about to change our health care system. People don't come up to me and ask me if I am a single payer or multiple payer, or pay or play or managed competition, or any of those labels. They ask me: Senator, will this new health plan cover me and my loved ones? Will it offer a decent package of benefits? Will I be able to afford it? Will I be able to choose who I go to for care? And I'd add another concern, that I'd like to hear more often, and that is, will the health plan be accountable? Will I be in the loop, when decisions are made about the kind of care I'll be getting, and how much it costs?

The American Health Security Act answers each of those questions with a resounding, "Yes!" We must provide universal health coverage to all Americans, and we must control spiralling health care costs. It would not only be an affront to the American people to do one without the other, it would not only be politically almost impossible, it would also plain not work. One of the clearest lessons we can learn from comparing other countries with our own, which spends ever increasing sums to cover an ever shrinking fraction of our population, is that we must include everyone in the same system if we have any hope of controlling costs.

Because it squeezes the administrative waste out of our current system, the single payer model would make universal coverage affordable. And because it brings to bear the power of a single public authority to bargain over expenditures with all of the providers of care, it can keep our system cost-efficient on an ongoing basis.

Canada pioneered the particular single payer system on which you and I have modeled our legislation. We have several distinguished witnesses with us here today to discuss the essential elements of the Canadian system, and I am looking forward to hearing from them both the advantages and the disadvantages. We also hear a great deal about Canada that I would consider misinformation, and I expect today we will also hear some discussion of what is fact and what is fiction.

But I want to say, as my friends in Canada have taught me, that although there are essential elements of the Canadian system that we would do well to recreate in the United States, there are many distinctively U.S. features that are positive and upon which we should build. The American Health Security Act acknowledges, for example, that we do and will continue to spend 40 percent more than our neighbors to the north on health care. We simply eliminate the bureaucratic bloat, and shovel the savings into health care.

We would also encourage some of the innovative features of our health care delivery system. We would encourage managed care programs to exist. But they would have to compete with other caregivers based on the quality of their care, not on the basis of lower charges. We would encourage the training and employment of a wide diversity of caregivers, including advanced practice nurses and physician assistants, to extend primary and preventive care as quickly as possible into every corner of our country, with special emphasis on underserved rural and inner city areas.

I think it is significant that today we also have with us a panel representing both U.S. doctors and nurses who support single payer. Increasingly I am hearing from caregivers, including social workers, dentists, hospital administrators and hospital workers, who are worried about preserving and improving the quality of patient care. They are concerned about the growing domination of insurance- and business-owned managed care networks in the provider community. It is going beyond complaints about the hassle factor we have heard so much about, to deep misgivings about the denial of needed services, the wrenching of long-term patients from one provider to another, the doubts about whether a critical Pap smear test was really read reliably.

I believe firmly that corporate medicine may serve the bottom line, but will never be driven to provide the king of high quality, patient-centered care that every American expects and deserves. Consumers and caregivers must make the critical decisions that will determine the quality of care, from where the next hospital should be built or the next MRI should be bought, to the day to day decisions about particular treatments.

As we move closer as a nation to comprehensive health care reform, people are looking more closely at the single payer proposal. The Beltway insiders always raise a skeptical eyebrow, but somehow around the country the more people learn about single payer,

the more it makes sense. It makes sense because it does control costs, it does provide universal coverage that is affordable both for people and for the Nation, it provides choice, and it puts consumers and caregivers in the driver's seat.

Most recently, the Citizens' Jury, a panel of 24 independent citizens from around the country, came out strongly in favor of a single payer approach. It came up from behind. There were 5 days of testimony presented on the President's plan and the Republican plans, with half an hour on single payer. But the proposal is so sensible, it caught the panel's interest. They invited me to speak to them again, three times, and ultimately expressed support for single payer.

The Washington, DC health department also recently pointed out that the single payer proposal would best meet the needs of the urban population they are pledged to serve.

Nevertheless, we face an uphill battle in Congress even to pass the mildest measure, a provision that each State should have the option to adopt a single payer system if it wants to. This is an extraordinary position, from people who generally are quick to defend the autonomy of States. But the forces that would defend the status quo have gone on record that they will fight any provisions that gives States the ability to choose how to run their health systems, if the choices include single payer. I believe that single payer is the best approach for the Nation, and I will continue to advocate that position. But I will also fight for the right of any State to implement a single payer system, regardless of how the rest of the Nation goes, and to do so without burdensome obstacles and bureaucratic delays.

I want to acknowledge the written testimony that is being submitted today in writing by some individuals and organizations who have given a great deal of thought to the issues before us, and ask that their statements be included in the record. They include statements by the Communication Workers of America, Vincent Rubino of Hope Homes, the Gray Panthers, and ACT UP/Washington DC. I would ask that the record remain open for further submissions of testimony.

I thank each of the witnesses for joining us here today. Whether you speak in agreement or disagreement with my own point of view, we have a lot to learn from you, and I look forward to hearing your testimony.

Senator METZENBAUM. Thank you, Senator Wellstone, and apropos your comments concerning the Citizens Jury that met here in the past week, there was a very interesting article in the Washington Post this morning indicating the same conclusions that you have just recited and, without objection, that article will be included in the record at an appropriate place.

[The article referred to follows:]

[FROM THE WASHINGTON POST—TUESDAY, OCT. 19, 1993]

THE SINGLE-PAYER DECISION

BY WILLIAM RASPBERRY

The Clinton administration claims to be close to transforming its health care reform plan into legislation. Before the end of the month, it tells us—maybe even before the end of the week.

Sorry, Hillary. Forget it. The plan's no good.

Who says so? Two-dozen public-minded citizens who know more about health care reform than 99 percent of the American people—including the Members of Congress who are supposed to enact the package so painstakingly put together by the First Lady and her hordes of experts.

The Citizens Jury, which spend most of last week looking at various reform proposals, voted 19 to 5 to reject the administration plan. A Republican alternative offered by Sens. David Durenberger of Minnesota and Don Nickles of Oklahoma was dismissed without a vote. What did the jurors like? The single-payer plan of Sen. Paul Wellstone (D-Minn.)

Perhaps the most interesting thing about last week's verdict is its defiance of the inside-the-Beltway wisdom that says a single-payer (Canadian-style) plan can't be passed. These jurors think it can be—and that it ought to be.

I say the administration and Congress ought to listen carefully.

To remind: The Citizens Jury, brainchild of a wealthy Minnesotan named Ned Crosby, is a paragon of representative democracy. Its 24 members, selected from a random sample of 2,000 adults on the basis of age, gender, politics, geography, ethnicity and other demographic specifics, represent a true cross-section of America. But unlike other supposedly representative bodies (the House of Representatives, for instance), these men and women manage to rise above their demographic identification. To an astounding degree, they bend their efforts to the good of America.

When it comes to health care, they said last week, the good of America is in universal health care coverage with a single payer. But not just any single-payer plan. They want Congress and the President to cooperate on a plan that embraces some 25 specific criteria, including portability, malpractice caps, reduced bureaucracy, reasonable pharmacy and hospital charges and preventive care.

The Clinton plan, they said, is vague on costs and would create an additional layer of bureaucracy, while the Republican plan doesn't go far enough. They think the American people deserve a look at other plans—including some approaches the jurors didn't even know about before last week.

Wellstone, who wasn't even on the original list of witnesses, was hustled over to the session when the jurors said they wanted to hear more about the single-payer idea. Wellstone, who has introduced such a measure, so impressed them that they had him back a second and a third time. In fact, when the Minnesotan dropped in at the jury's farewell dinner Thursday night, he got a standing ovation.

The Clinton numbers just didn't add up and would create more bureaucracy, said Judith Thrane, a registered nurse from Louisiana, reflecting what appeared to be the jury's consensus. The Republican proposals were jut a Band-Aid on a hemorrhaging wound—The Wellstone plan offers just one bureaucracy, the Federal Government. Tax it, pay it, and get it over with.

The jurors' misgivings regarding the Clinton plan are not so much a slap in the administration's face as a reminder of how difficult it can be in this greatest of all democracies for people to make informed choices.

Face it: We don't know what's in the Hillary Clinton package or the Republican alternative. Much of what we know about the Canadian plan is vague and anecdotal (it covers everybody, but you have to come to the United States if you want a hip replacement or a CAT-scan). Our attitudes toward the various propositions are influenced less by their content than by the interpretations of people with axes to grind; physicians who would be affected by price controls; insurance companies that stand to make a killing or get killed, depending on which plan is adopted; ideologies who favor or oppose government involvement quite apart from the practical consequences of that involvement—even the seemingly benign American Association of Retired Persons, whose insurance company would lose a lot of money under a single-payer plan.

Nor can we trust our elected representatives to represent our views, so in thrall are so many of them to these same special interests.

What we'd really like is the time to learn the intricacies of this complex subject, access to relatively unbiased expert opinion and the ability to cross-examine advocates and opponents of various approaches.

And that, by proxy, is what the Citizens Jury approach provided last week.

The administration, listening to the political counsel of insiders, probably will move in the next several days to try to enact its admittedly imperfect plan.

I'm inclined to listen to the advice of the Citizens Jury: Slow down, and reconsider the single-payer approach—and never mind the conventional wisdom that says it can't pass.

Senator METZENBAUM. The committee has a rather full agenda by the time we get through with our questions, and I think we have asked the witnesses to confine themselves to 5 minutes. We will be a little bit lenient on that, but probably the ax will come down at 6 or 7 minutes.

We are happy to have you, doctor. Please proceed.

STATEMENTS OF DR. FRANK J. INDIHAR, ST. PAUL, MN; DR. VICTOR W. SIDEL, ON BEHALF OF THE PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, NEW YORK, NY; PATTI TRIPOLI, ON BEHALF OF THE NEW YORK STATE NURSES ASSOCIATION, MINOLA, NY; AND DR. MELVIN KONNER, ASSOCIATE PROFESSOR OF PSYCHIATRY AND NEUROLOGY, EMORY UNIVERSITY, ATLANTA, GA

Dr. INDIHAR. I am Dr. Frank Indihar, of St. Paul, MN. Thank you, Senator Metzenbaum, for calling this hearing, and Senator Wellstone for asking me to testify on this very important issue.

The delivery of health care, I believe, is a most personal and intimate process, and when we look at this health delivery system, a thorough examination of the most fundamental relationship in that delivery system, the doctor-patient relationship, I believe should receive primary consideration. This virtually sacred relationship, which involves not only the practice of the science of medicine in all of its wonderful aspects, but also the art of medicine, revolves equally on the relationships that develop over long periods of time between doctors and patients.

In my case, this relationship has developed many fine friendships, and it is a pleasure to be working with my colleagues at St. Paul Internists, a group of 8 general internists and 4 cardiologists, and be able to take care of a range of patients that have been my current patients, their parents, their grandparents, and to some of my senior partners even their great-grandparents, over a period of time.

Now, as you may know, Minnesota has been a laboratory for managed care systems for the past 15 years. We have evolved and seen the development of multiple health maintenance organizations, indemnity programs, employed physician maintenance organizations, hospital physician organizations, independent physician organizations, buyer coalitions, buyer alliances, and recently a clinics-without-walls model being developed.

The net result that I as a practicing physician am seeing in this highly competitive environment that has indeed had some degree of cost containment—the price that has been paid is the gradual erosion of the most fundamental health care delivery relationship, and that is that which develops between the doctor and the patient.

Going a step further, because of the impetus provided by a group of buyers in Minnesota, the Minnesota State Legislature in 1992 adopted cost containment legislation entitled MNCare. A health care commission was formed which, after some deliberation,

evolved another health care experiment via integrated health networks. These networks are large coalitions of insurers, hospital corporations, and physician employees who will provide care to segments of the population.

The control of these networks has been seemingly vested in this new experiment in the hospital and insurance consortia that have been rapidly forming in the Minneapolis-St. Paul metropolitan area. Each of these consortia is busy trying to carve out a patient population to service in this marketplace. You will notice that I specifically left out the physician-patient component of this territorial division. It would seem that this concept, to date, has been the least concern of these consortia.

Unfortunately, physicians in Minnesota are becoming immobilized by the limited options available. They are given the choice to join one or another exclusive system or to perhaps go out of business or to retire early or to leave and go some place else. The patients, of course, are left wondering who they will have care from next year or when the next ISN, integrated service network, bids for their employees' health business. Insurance companies and hospital corporations that are reeling like gigantic Titanics from loss of patients and empty hospitals are struggling to buy physicians' medical practices to provide them a patient stream.

In Minnesota, this managed care frenzy that is underway has led to the, in my view, absolute ascendance of corporate-controlled medicine. The corollaries to this approach, unfortunately, the loss of the doctor-patient relationship. I can speak very personally to this phenomenon. Just this last month, the State of Minnesota—and we have offices that are very close to the State complex, so many of the State employees use the services of my partners and myself. Many of the State judges rely upon us.

The State of Minnesota changed from one Blue Cross/Blue Shield plan to another. Our office, which had approximately 750 patients enrolled in this plan, was not listed as a provider in the other Blue Cross/Blue Shield plan. We have had panicked calls from desperate patients. They are lost in the system; they have not been asked for their input. They are asking us what direction to take, and they were given 30 days to find a new health care provider and this has happened within the past 20 days.

This has led to many painful moments on my part, as I have had to take leave of many of my patient friends that I have developed for many years of close association and care. Incidentally, our efforts to be included on the new plan's list has hit many roadblocks and, as it turns out, Blue Cross/Blue Shield has actually purchased a clinic that will be providing this care in the Twin Cities area.

So I think that the point is that the loss of physician autonomy in the managed care environment is striking. Physicians recognize the need for health care to be accessible and affordable for all. I think this is a basic tenet of physicians throughout the years, and it is certainly the position of organized medicine.

Physicians are virtually universally ready to participate in changes in a system that will benefit our patients and at the same time be cost-effective. But physicians want to participate in the discussions and be advocates for the preservation of this wonderful doctor-patient relationship.

Now, physician autonomy, by this definition, is the ability to make the best choices for your patient, regardless of corporate pressure relative to cost containment and bottom-line thoughts. Autonomy also means the ability of a physician to practice in a setting to which they are best suited, and that may not be in the corporate setting.

The managed health care environment has also definitely restricted patient choice of physician in Minnesota. Interestingly, at the Minnesota Medical Association meeting, because of these changes in the environment, the Ramsey County Medical Society formulated a resolution asking the Minnesota Medical Association house of delegates to look at the single-payer system as an option to what we are seeing happen with the managed care systems.

The testimony presented by many of the physicians was overwhelmingly in favor of looking at this option. Eventually, the resolution was taken to a vote of the Minnesota house of delegates, and this occurred just in early September. On a vote of 86 to 80, the proposition lost, but I was totally amazed that 80 physicians said, yes, they want to look at the single-payer option.

We recognize what is happening with the managed care in the Twin Cities.

Senator METZENBAUM. What group was this again, Dr. Indihar?

Dr. INDIHAR. This was the Minnesota Medical Association house of delegates in early September.

Senator METZENBAUM. Is that an affiliate of the American Medical Association?

Dr. INDIHAR. It is.

Senator METZENBAUM. Thank you.

Dr. INDIHAR. So it is my fervent hope that a health care delivery system be developed that will preserve the doctor-patient relationship, preserve physician autonomy, allow the physician to make the best choice for his patients free from corporate interference, and provide patients with a true choice of physician.

The Minnesota experience, I think, would seem to indicate that the managed care model does not necessarily meet these criteria. Therefore, I believe that a thorough study of the single-payer system must be carried out before settling on the managed care model. Although I realize that the specter of the Canadian health system is always raised when compared to a single-payer model, together with both its anecdotal positive and negative aspects, I believe that a system can be formulated that would be uniquely American. With appropriate caveats to avert the pitfalls inherent in other single-payer systems, perhaps an American single-payer system that follows the criteria of autonomy, choice, fairness, and accountability can be fashioned.

This testimony is not an unequivocal endorsement of the single-payer system. It is a plea, however, for serious study of this system as an option. The Minnesota experience, I believe, would suggest that the managed care model may be an unsatisfactory delivery mode, and I believe that 50 percent of the physicians represented at the Minnesota Medical Association's house of delegates meeting would agree with this view.

However, as with any fine impressionistic painting, both the single-payer and managed care models seem to have a wonderful pic-

ture when looked at from afar, but when you get close the details blur. What I would ask for is let us develop together a single-payer option and single-payer details, and then judge this option fairly.

Thank you.

Senator METZENBAUM. Thank you very much, Dr. Indihar.

[The prepared statement of Dr. Indihar follows:]

PREPARED STATEMENT OF FRANK J. INDIHAR, M.D., F.A.C.P.

I must thank the Co-Chairs of this hearing, Senator Paul Wellstone and Senator Metzenbaum, for calling this hearing on the Single Payor System Health Care financing alternative and for giving me a chance to testify on this very important issue. The delivery of health care is a most personal and intimate process. Too often health care policy makers look only at the aggregate picture in evolving a policy that touches so many individuals, whereas when we examine the microcosm, we can often find the answer to the confounding problem.

When we look at health care delivery, a thorough examination of the most fundamental relationship in that delivery system, the doctor-patient relationship, should receive primary consideration. This virtually sacred relationship, which involves not only the practice of the science of medicine in all of its aspects, revolves equally on the relationships that develop over long periods of time between doctors and their patients. In my case, this relationship has developed many fine friendships; I treat my patients as my friends and, I believe, this leads to a higher quality of caring, compassionate care that is necessary to the successful practice of medicine.

I am a graduate of the University of Minnesota Medical School and have been in the practice of general internal medicine in St. Paul, Minnesota, with my partners in St. Paul Internists, P.A., a group of 8 general internists and 4 cardiologists, since 1973. Our practice has been in existence in St. Paul since 1923 and has developed a fine relationship with many citizens. It has been a pleasure for my partners to have taken care of the parents and grandparents and great-grandparents of some of our current patients, all of whom feel comfortable in our offices and with the care they receive. It is the loss of this ability to provide the type of continuity of care in a compassionate, caring environment that we are experiencing in Minnesota today and which, I fear, may develop throughout the United States unless a health care delivery system is developed which preserves this most humane aspect of medical care.

REVIEW OF THE MINNESOTA HEALTH CARE ENVIRONMENT

Minnesota has been a laboratory for the managed care systems for the past fifteen (15) years. We have seen the development of multiple health maintenance organizations (HMOs), indemnity programs, employed physician health maintenance organization, hospital-physician organizations, independent physician organizations, buyer coalitions and alliances, formed during this period of time. The net result of this highly competitive environment has been a degree of cost containment, but the price that has been paid is the gradual erosion of the most fundamental health-care delivery RELATIONSHIP, that which develops between doctor and patient.

However, with the escalation of health care costs, which has multiple factors with which you are all well acquainted, the consumers in Minnesota represented by several large corporations, formed a Buyer Coalition in an attempt to hold the escalation of health care costs to an affordable level. The impetus provided by this group of buyers encouraged the Minnesota State Legislature, in 1992, to adopt cost-containment legislation titled MNCare. A Health Care Commission was formed which, after deliberation,evolved a health care delivery system in Minnesota via Integrated Service Networks, large coalitions of insurers, hospital corporations, and physicians, to provide care to the patients. The control of these networks has seemingly been vested with the hospital and insurance consortiums that have been rapidly forming in the Minneapolis-St. Paul Metropolitan area, each trying to carve a patient population to service. You will note that I specifically left the physician-patient component out of this territorial division; it would seem that, to date, the least concern of these consortiums, is the doctor patient relationship.

Even though the networks are only in the formative stage, the scene in Minnesota is, frankly, one of utter chaos. Physicians are immobilized by the limited options available: to join one or another exclusive system or go out of business; patients are left wondering who they will have care for them next year, or when the next ISN bids for their employerls health business. Hospital corporations, like gigantic

Titanics, reeling from a loss of patients and empty hospitals, are struggling to buy physicians' medical practices to provide a "patient stream." Physicians, unsure of their futures are, in many instances, taking early retirement or moving from this hostile environment to other areas which have, thus far, tried to preserve the doctor-patient relationship with other methods of health delivery.

MANAGED HEALTH CARE/INTEGRATED SERVICE NETWORK RESULTS

In Minnesota, the managed care frenzy that is underway has led to the absolute ascendance of corporate-controlled medicine. The corollaries to this approach, unfortunately, have been loss of the doctor-patient relationship. I have recently had personal experience with this phenomenon. Our group has long been a provider in the Minnesota State Health Plan provided by one of the Blue Cross/Blue Shield products. Our offices are conveniently located near the State Capitol complex and many of the State's employees, and subsequently, their families, have chosen us to provide their care. Our office was proud to have many of the State judges and their families rely on us as well. However, we recently discovered that Blue Cross/Blue Shield had developed another product for the State of Minnesota, and our group was not among the providers listed for that particular product. Our office has been inundated with calls from desperate patients, lost in the system and not asked for their input, about what direction they should take; they were given 30 days to "find" a new health care provider. This has led to many painful moments as we have had to take leave of our patient-friends after many years of close association. Our efforts to be included on the new plan's list has hit many roadblocks and likely will not be possible.

The loss of physician autonomy in the managed care environment is also striking. I must comment that physicians recognize the need for health care to be accessible and affordable for all; this has been the basic tenet of physicians throughout the years and certainly is the position of organized medicine today. Physicians are ready to participate in changes in the system that will benefit our patients and, at the same time, be cost effective. I believe that, in my conversations with physicians across our State in my position as an Alternate Delegate to the American Medical Association's House of Delegates and a Delegate to the Minnesota Medical Association's House of Delegates, that this willingness to change is universal! But, physicians want to participate in the discussions and be advocates for the preservation of the doctor-patient relationship. Physician autonomy, by this definition, is the ability to make the BEST choices for your patient, regardless of corporate pressure relative to issues of cost containment. Physician autonomy means allowing physicians to continue to provide patients with the BEST OPTIONS available, not only those options dictated by preservation of the bottom line. Autonomy means the ability of a physician to practice in a setting to which they are best suited, not forced to practice in a corporate setting and to leave their private practice and entrepreneurial approach. However, these comments should not be misinterpreted; physicians are anxious to follow practice parameters and protocols, providing these protocols are in the patient's best interests and not just to provide bottom-line improvement. Physicians are anxious to be accountable and provide the best quality of medical care, as is currently the case across the United States and in Minnesota (often called the healthiest State in the nation). Physicians are anxious to learn; this is the bedrock of their educational experience.

However, physicians resent the "micro-management" of patient care that has occurred in the managed care setting; this is evidenced by the numerous demands placed on physicians in Minnesota for pre-referral authorization, pre-hospitalization authorization, blood testing authorizations, to mention just a few. This second guessing of a physician's knowledge is onerous and, again, severely restricts a physician's ability to exercise appropriate care for his patient.

The managed health care environment has, finally, definitely restricted patient "choice of physician" in Minnesota. Physicians belong to certain plans; these plans are changed by buyers on a regular basis. Patients are prevented from continuing to see the physician of their choice by the exclusive nature of these plans. The ISN (Integrated Service Network) program being contemplated by the MN Care Legislation is fostering large, EXCLUSIVE, cadres of physicians; patients, who will be shunted from plan to plan dependent on generally cost factors, will likely be changing their physician relationship frequently in this model. One criticism of the Clinton Plan, although there are many positive aspects, is the promise of "choice" WITHIN a network. What the networks practically develop is in an exclusive mode; physicians are NOT allowed in every plan and patients are NOT given complete choice!

SINGLE PAYER SYSTEM SOLUTION

Due to the formation of the service network model of health care delivery developing in Minnesota, many physicians in Ramsey County (St. Paul, MN metropolitan area) began to search for an alternative model that would provide a continuance of the physician-patient relationship. Senator Wellstone spoke to the Ramsey County Medical Society approximately two years ago on the merits of the "Single Payer System"; at that time, his ideas were met with considerable skepticism. However, the single payer merits of physician autonomy, preservation of the doctor-patient relationship and true patient "choice" of physician were soon seen to be inherent only in this mode of health delivery system. Accordingly, the Ramsey County Medical Society prepared a resolution to the Minnesota Medical Association's House of Delegates that did not necessarily endorse the single payer model, but asked that this model be thoroughly studied, compared with the managed care system model in all aspects, and that physicians, consumers, legislators and health policy experts be educated regarding this option.

The response of physicians at the Minnesota Medical Association's House of Delegate's meeting in September, 1993, was astounding! The testimony heard at the reference committee was overwhelmingly in favor of researching in depth this approach to health care delivery. It became evident that physicians are concerned about their ability to practice effectively as patient advocates in the managed care environment; rather they generally felt that they would become mere allocators of care! Much concern was also voiced about the corporate takeover of the health care delivery system by insurance companies and hospital corporations in the managed care setting envisioned by MNCare; as evidenced previously, these takeovers are well underway in Minnesota, spelling the end of choice, autonomy, and relationship! The Reference Committee report went even further than the Ramsey County Resolution by asking that, in addition to education, the Department of Health be asked to set aside a county in the State to serve as a pilot project for the system to determine its efficacy!

The House of Delegates, after much discussion which generally focused on the fact that the managed care approach was too far along in Minnesota to be changed, eventually defeated the proposition on a very close vote of 86-80. This near 50 percent of physicians in the State who were willing to be educated about the Single Pay Model, and, perhaps adopt it if, with certain caveats regarding the implementation of the program could be guaranteed, is, to me, amazing. It is an indication of the degree of doubt that exists concerning the validity of the managed care model in 'the medical community. It is further, I believe, an affirmation of the physicians' desire to continue to serve as the primary patient advocate by preserving the doctor-patient relationship via another model, which would seem to best be served by the Single Payer System.

CONCLUSION

It is my fervent hope that a health care delivery system be developed that will preserve the doctor-patient relationship, preserve physician autonomy to make the best choices for his patients free from corporate interference, and provide patients with true "choice" of physician. The Minnesota experience would seem to indicate that the managed care model does NOT meet these essential criteria. Therefore, a thorough study of the single payer system, an educational process for physicians, patients, policy makers and legislators regarding the realistic pros and cons of each model, and the adoption of an, option that most satisfies patient needs must be carried out before settling on the managed care model. Although the spectre of the Canadian System is always raised when compared to the singer payer model, together with its anecdotal positive and negative features, I believe that a system can be formulated that would be uniquely AMERICAN. With appropriate caveats to avert the pitfalls inherent in other single-payer systems, perhaps an AMERICAN SINGLE PAYER SYSTEM that follows the criteria of autonomy, choice, fairness, accountability and preservation of the doctor-patient relationship can be fashioned.

This testimony is NOT an endorsement of the single payer system; it is a plea for serious study and development of this option. The Minnesota experience, indeed, would suggest that the managed care model is an unsatisfactory delivery system, with 50 percent of the physicians at the Minnesota Medical Association's House of Delegates meeting agreeing with this view. However, as with a fine impressionistic painting, both the single payer and managed care models seem beautiful when viewed from the distance, but blur when examined in detail. Let us develop together the single payer details, and then judge this option fairly. Thank you.

Senator METZENBAUM. I think we will hear from all the members of the panel before we open the floor to questions, but I am very pleased that Senator Jeffords has joined us. Senator, do you have some comments you would like to make?

Senator JEFFORDS. I have no comments.

Senator METZENBAUM. Dr. Victor Sidel, representing the Physicians for a National Health Program, of New York. We are happy to have you with us, Dr. Sidel.

Dr. SIDEL. Thank you, Senator Metzenbaum. It is a privilege to be before your committee. I thank you for calling these hearings. I think we are sitting here at an exciting moment in the history of U.S. health care. I think there is now a sea change in terms of what the public and what people in this city are beginning to think about in terms of health care reform.

As we have already been told, the politicians have told us that single-payer was not politically viable. It is becoming politically viable, and these hearings will go down in American history as one of the turning points for the viability of the single-payer option, and I am grateful to Senator Wellstone and his staff for my ability to be part of this historic moment in that health care debate.

Along with other qualifications that are in my testimony—and if I may, Senator Metzenbaum, I will ask that my whole testimony be put in the record so I can be very brief now.

Senator METZENBAUM. Without objection, the testimony of all of the witnesses will be included in the record as printed.

Dr. SIDEL. Perhaps the most important qualification that I have for sitting here is that I work in the Bronx, and that very name tells you some of the problems that we face in trying to provide health care for the people who are our neighbors, who are our patients, who are our friends. So we were thrilled, we were overjoyed when we heard that President Clinton was going to put high on the U.S. agenda a change in the U.S. medical care system. We thought that was desperately needed. He told us it was broken and we had to fix it, and we said, amen, it is broken and it has to be fixed.

Then what we heard, unfortunately, was a plan that, in our view, does not fix it. I don't have time in my 5 minutes to go through all of those issues. I will just name them. They are covered in detail in my testimony.

For one thing, the plan is not universal in its coverage. Undocumented people in the United States are not covered. Migrants workers are barely covered. Transient populations are covered badly, and for New York City and for New York State it will be a disaster if undocumented people are not covered within health care reform.

We know that the financing is regressive. We know that people who are poor will pay more within that financing system that is proposed, and the people of the Bronx cannot tolerate a regressive health care financing system. We know that choice will be desperately limited, and people in the Bronx and people in many cities of these United States already have their choices limited in any number of ways. They have to be able to make choices in at least one aspect of their lives, which is how they are going to get medical care, and what the President is proposing unfortunately will not permit them to have those choices.

The President's proposal also does not offer us the hope of any kind of decent cost saving. Again, the testimony covers in detail after detail the issues about why the cost containment within that program is not going to work, and one of the major reasons, in our view, is that it permits a continuing role for the 1,500 commercial insurance companies in these United States which have helped to engineer the failure of the current system and now will be permitted to continue to milk it and continue to cause chaos within it.

We know, for example, that a study in September 1993 by Marion Merrell Dow found that 21 of the 25 fastest growing HMOs were for-profit enterprises, and that the big 8 among insurance companies—that is, Blue Cross, Cigna, Aetna, Travelers, MetLife, Prudential, Humana, and United Health Care—owned 45 of the 562 HMOs in the country. In other words, it is giving the system back to those who have helped to destroy it, and we feel that has to change.

Now, there is an alternative. The alternative is called single-payer. It is not, as Dr. Indihar said, without its problems, and we think there has to be a lot of exploration of those problems, but it is a way of attempting to save somewhere between $70 billion and $120 billion per year in current administrative costs within this system. That would permit us to cover everyone residing in the United States, whether documented or not, whether a migrant worker or not, whether a transient or not.

It will permit us to give a decent benefit package to every person in the United States, including the kind of preventive care that President Clinton calls for, but does not have the resources within his plan to provide. It will permit a financing system that will be progressive and will share the burden among the people of the United States in the way that burdens should be shared.

In S. 491, Senator Wellstone's bill, there are, furthermore, sharp restrictions on the ability of profit-making enterprises to take over the system yet again, and therefore Physicians for a National Health Program particularly supports S. 491 because of these restrictions on profit-making enterprises.

Let me say, in closing, because the yellow light, I see, is on, that just fixing the medical care system is not going to be sufficient. Certainly, we need within that medical care system to build in what is called preventive medicine—mammograms, preventive care of various kinds. But that is not enough. What also has to be fixed in the United States, because it is broken, is the public health system, and we have to put more resources into that form of public health, not just preventive medicine, within doctors' offices.

Perhaps most important for the people of the Bronx, we need a decent kind of society that provides jobs, that provides the kinds of income supports when people don't have jobs, that provides the kinds of services that lead to health for people because medical care by itself—not even preventive medicine within medical care is going to make a great change in the health of people. It is public health and it is the way people live that makes people healthy.

Let me conclude with just one other point, I promise just for less than a minute, and I will quote from the Atlanta Journal Constitution in an editorial on September 11, 1993. They said, "The case

for a single-payer system is a strong one. The fight for it must be waged vigorously in Congress, even as the odds now stand heavily against it. It must remain a viable option for the day when a combination of national need and political courage make its implementation possible."

Senator Metzenbaum, I know of no one in this Congress, including Senator Wellstone, whom I admire greatly, who has shown more political courage, sir, than you have. I admire, as I said, Senator Wellstone and what he has done in this Congress, and Senator Jeffords as well. The moment for political courage is now, the national need is now, the time for single-payer is now. I think we are seeing a turnaround and I would like to see it move forward from these hearings to a real plan for the United States.

Senator METZENBAUM. Thank you very much, Dr. Sidel.

[The prepared statement of Dr. Sidel follows:]

PREPARED STATEMENT OF VICTOR W. SIDEL, M.D.

I appreciate the opportunity to present this testimony before you today. My name is Victor Sidel. I am a physician and serve as Distinguished University Professor of Social Medicine at Montefiore Medical Center and the Albert Einstein College of Medicine in the Bronx, New York. I am a member of the national Board of Directors of the Physicians for a National Health Program (PNHP), on whose behalf I testify today. In addition, for identification, I am a Past President of the American Public Health Association, a Past President of Physicians for Social Responsibility and was recently elected CoPresident of the International Physicians for the Prevention of Nuclear War, recipient of the 1985 Nobel Peace Prize.

PROBLEMS IN THE US HEALTH CARE SYSTEM

As President Clinton pointed out in his address to the Congress, it is widely recognized today that in terms of access to care, quality of care and cost the U.S. health care system is "broken" and requires "fixing. " Unfortunately the President noted only a few of the dysfunctional elements in our current system. I will start by briefly summarizing our view of the extent of the problems, problems that in our view require change much more fundamental and much different than President Clinton has proposed.

Access: Barriers to access to health care in the U.S. include large out-of-pocket costs at the time of need for care, geographic maldistribution of services, and widespread racial, sexual, homophobic and economic discrimination. In the U.S. limitation of access is largely accomplished by limitations in the coverage of public or private insurance programs that reimburse medical expenses and by failure of the public sector to provide accessible or acceptable services, rather than by formal queuing based on medical urgency. Patients with adequate private resources or with comprehensive insurance coverage can usually obtain expeditiously the services they need or want, but access is limited for many working-class and indigent people.

Large groups, including many employed workers, students and poor people not covered by Medicaid, are completely uninsured against the costs of medical care. The number of uninsured people in the U.S. has increased over 30 percent since 1980. In 1980, 66 percent of people living below the federally-established poverty line were enrolled in Medicaid; now fewer than 40 percent are enrolled. Among all people age 64 or younger, 35 to 40 million people including some 12 million children, are not currently covered; over a 28-month period some 63 million were not covered for at least one month.

Beyond the millions who are completely uninsured, another large group of people in the U.S.—estimated at 50 million—are severely underinsured. Some 20 million people have medical insurance so inadequate that a major illness could mean financial ruin. Large out-of-pocket co-payments are often required and the services covered by insurance are often less than comprehensive. Preventive and rehabilitative services are often omitted. Almost all people age 65 and older are covered by our Medicare program, yet despite this coverage they now as a group pay out-of-pocket more than 50 percent of their medical care expenses. This amounts, on the average, to approximately 20 percent of income and for many older people it is of course far higher. Even with the massive governmental payments for Medicare, the out-of-pocket payments constitute a higher percent of income paid out-of-pocket for medi-

cal care than those age 65 and over paid before Medicare coverage was established for them in the 1960s!

For people under age 65, medical care insurance is usually tied to employment. Many U.S. workers are unwilling to move to other jobs because they fear they will not obtain comparable coverage. Furthermore, many labor unions have sacrificed higher wages and better working conditions through collective bargaining in order to negotiate better medical care coverage.

Lack of insurance coverage has been Clearly documented to limit access to care, particularly to non-emergency care. A recent study, for example, found that 64 percent of insured women were adequately screened by breast examination compared to 50 percent of uninsured women and that 72 percent of insured women were tested for glaucoma compared to 57 percent of uninsured women.

Even for those who are insured, coverage does not make access equitable. While this is true in many countries with relatively equitable health care systems, the problems are more pronounced in the U.S. Since lower and slower reimbursements are given to medical care providers by Medicaid than by Medicare or private insurers, many doctors and medical institutions deny or limit access to Medicaid patients. Other barriers include geographic maldistribution of personnel and facilities and difficulties in access associated with poverty, race, age, language, sexual orientation and social conditions such as homelessness.

The Journal of the American Medical Association in a May 1991 editorial pointed out that one of the major reasons for the lack of universal access to medical care in the US (along with South Africa) is "long-standing, systematic, institutionalized, racial discrimination." For example, although they were all covered for costs by the End Stage Renal Disease Program, only 20 percent of African-American patients on dialysis received renal transplants in 1983 compared to 30 percent of white patients, only 21 percent of women compared to 31 percent of men, and only 3 percent of those over age 55 compared to85 percent of those aged 11 to 35. Studies in Boston demonstrate similar bias on the basis of race and sex in access to care for coronary heart disease.

Quality: Along with its failure to provide needed services, the U.S. relies in large part on a fee-for-individual-service reimbursement system that provides hard-to-resist incentives to supply unneeded services to those who are insured or who can pay privately for them. Conversely, because of duplication of services, many doctors and institutions perform too few procedures for maintenance of needed skills. Overall there are major discontinuities in care caused by a fragmented system that relies predominantly on specialists and on high-technology care rather than on primary care with appropriate referrals.

Attempts made to improve quality of care through "managed care," such as Health Maintenance Organizations (HMOs), have had mixed results. A recent study at Johns Hopkins demonstrated that people in HMOs are not as satisfied with their care a- are people in other forms of care. The Rand Health Insurance Experiment carried out in the 1970's, until now the only randomized trial of MO vs. fee-for-service care, found that MO patients suffered more serious symptoms (with a relative risk of 1.39) and spent more days in bed (relative risk 1.21) than comparable patients randomized to fee-for-service care, without co-payments. The MO studied, Group Health Cooperative of Puget Sound, is widely considered among the nation's best. A particularly disturbing finding from the Rand Health Insurance Experiment is that poor, high risk patients fared poorly when randomized to an MO. Diastolic blood pressure and overall risk of dying were both significantly higher in the MO members than in those receiving fee-for-service care with comprehensive coverage. In contrast, wealthy patients appeared to do well in the excellent MO used in the experiment.

Perhaps the most important failure in the quality of the system is that, although it is referred to as a "health care system," it is almost entirely a "medical care" system. Certain elements of health care can indeed be provided to individual patients and families with a medical professional-patient relationship; these elements, such as breast examinations for early detection of breast cancer and rectal examinations for early detection of prostate cancer, are usually referred to as "preventive medicine." In the U.S. third-party reimbursement to medical professionals for such services is usually extremely poorly or nonexistent and these services are typically provided far too infrequently. Even worse, in the U.S. the system for providing health services for everyone in the community, usually known as "public health services," is desperately underfunded and often unable to fulfill its mission, particularly in poor communities.

Cost: The cost of this fundamentally-blighted medical care system is the highest in the world, currently over 13 percent of GNP, on average more than $2,500 annually per person. Furthermore the cost is growing rapidly, far faster than inflation.

It has been estimated that the cost will approach 18 percent of GNP by the year 2000.

Among the reasons for these high costs are the large number of technically-based specialists compared to primary care doctors and the rampant duplication of services. Only 30 percent of U.S. doctors practice primary care compared to 50 percent of doctors in most industrialized countries.

One of the most important causes of the high costs is the immense expense to providers for billing and collection from patients and insurers, constituting a major part of U.S. physician and hospital expenses. Almost one-quarter of U.S. medical care expenditures are consumed by billing, attributing costs for services and supplies to individual patients, bad debt service and dealing with 1200 different commercial insurance carriers. The administrative cost in Canada's "single-payer" system is 11 percent of expenditures. Private insurance firms in the United States have an overhead of 13 percent of premiums compared to three percent in the U.S. Medicare and Medicaid programs and to one percent in the single-payer system in Canada Such administrative expenses of course divert resources from patient care.

Another major problem with the huge amount of resources flowing into the medical care system is the imbalance in their distribution.

There are enormous differences in income between primary care and specialist doctors and an even larger gap between doctors' incomes and incomes of other health workers. Extraordinary profits are being made by drug companies and other medical suppliers. Overall, the vast resources used by the medical care system represent theft from other vitally-needed public services such as education and child care and the wealth pouring into medical care selectively benefits the haves at the expense of the have-nots.

FAILURE OF THE CLINTON PROPOSALS TO ADDRESS THESE PROBLEMS EFFECTIVELY

The Administration has proposed a series of recommendations, not yet submitted to the Congress, to address these problems. In the final weeks of the 1992 U.S. presidential campaign the editors of the New York Times declared: "The debate over health care reform is over. Managed Competition has won." The term "managed competition" had been introduced by Ala in Enthoven, a Stanford University health economist, based on methods used in the U.S. Department of Defense during the Kennedy Administration; the term was popularized as a proposal for the U.S. health system by an informal group meeting in Jackson Hole, Wyoming, composed of health insurance and other health industry executives, health policy analysts and a few representatives of health care provider associations, including the Executive Vice President of the American Medical Association. Their clear purpose was to find a way to preserve the vast private medical care insurance industry in the U.S.

The term "managed competition" is appealing because those who believe that the free market can solve the problems of the U.S. health care system can embrace the noun while those who insist the government regulation is needed can endorse the adjective. The Administration's recommendations avoid the use of the term "managed competition," which has now become quite tarnished, but the concept clearly underlies their proposals. Competition is encouraged among large "managed care" groups called "Accountable Health Plans," to provide care for a defined insured population at low cost. Individuals and employees of small employers would become part of Health Alliances (originally called Health Insurance Purchasing Cooperatives by the Jackson Hole Group). Health Alliances would use their bargaining power to purchase an Accountable Health Plan for their members, presumably the plan with the lowest cost for a defined set of benefits; large employers may be permitted to "opt-out" and provide negotiated health care plans for their employees. A National Health Board would define a Standard Benefit Package, would support technology assessment programs and would provide information on quality and cost to the Health Alliances.

With regard to payment, the option selected by the Task Force is usually called "employer mandate" or "pay or play"; it requires employers to provide coverage for their employees or pay into a fund to provide coverage. In addition, taxes on alcohol and tobacco to cover part or all of the cost have also been suggested. Criticisms of the Clinton proposal include:

Universal Coverage: While one of the strongest elements of the President's proposal is its attempt to extend universal health care protection to virtually all people residing in the U.S., coverage is not extended to undocumented residents. For migrant workers and other transient populations there are also serious problems in coverage. Problems that need to be resolved. Additionally, the plan will not be extended to cover residents or U.S. citizens in Puerto Rico or the U.S. territories, instead health coverage for these individuals will operate as it does today. PNHP

therefore urges that all U.S. citizens and residents should be provided coverage and access to the health care system.

Elimination of Financial Barriers to Care: The proposal includes inequities in the proportion of income individuals will be required to pay for health insurance. For example, low-wage workers and some non-workers who are not eligible for a subsidy (e.g., subsidies provided to workers with incomes below 150 percent of poverty, non-workers below 250 percent) would pay an inordinate proportion of their income if they want to retain the freedom to choose their own doctor. Because employers' contributions for part-time workers would be prorated, the part-time employee would be responsible for the portion of the premium not picket up by the employer. The proposal also has cost sharing requirements for low-income individuals and families.

Comprehensive Benefits: Employers and purchasing alliances are likely to choose the lowest cost plan (presumably the Standard Benefit Package) available in their area. In order to enter a plan with a better benefit package or higher quality of care, individuals or their employers would have to pay with non-tax-deductible funds. It seems clear that the well-off are likely to have better benefit packages than the poor. Among other improvements in the benefit package for everyone, specific improvements are needed in the area of long-term care, in which the coverage should be expanded by lowering the activity of daily living (ADL) requirement from 3 to 2 for community-based care and by allowing for public financing of long-term nursing home care.

Choice of Providers: PNHP believes the Administration plan would force poor and middle-class people into stripped-down "managed care plans" in which there is little or no choice of physicians; only the wealthy would be able to select plans in which there is free choice of physicians. Since, as we have noted, the poor appear in general to be poorly served by managed care plans, the Administration's proposal is not only an unjust maintenance of a multi-tiered health care system but a severely dysfunctional imposition on the disadvantaged of our society.

Cost Control: PNHP finds no evidence to suggest that the Clinton proposal will be effective in cost control. More than a third of the U.S. population lives in areas with populations under 200,000, smaller than is regarded as necessary to support a single managed care plan; these areas could not support more than one plan and "competition" would be unlikely. Furthermore, managed care is not likely to control costs even where more than one managed care plan exists. Cost for managed care plans in the U.S., despite one-time reductions at the time of initial establishment, are rising at the same rate as traditional insurance plans. Managed competition does not significantly reduce the administrative costs built into the current system and will institute another layer of bureaucracy between the patients and the insurers who contract with doctors and hospitals.

Even more important, PNHP believes that the Administration proposals would introduce a huge new regulatory apparatus that would lead to increased costs rather than to effective cost containment. It believes the projected Medicare and Medicaid savings of $239 billion between 1996 and 2000 to be not only unjust and dysfunctional, but totally unrealistic. Similarly, it believes the Administration's projections of decreased growth in medical care expenditures under its plan to be grossly exaggerated. People now served by Medicaid would be switched to the private system, with its much higher administrative costs, and there will be a multi-billion dollar cost in setting up the new layer of administrative function, the Health Alliances.

Finally, one of the most important reasons the Clinton proposal will fail in its cost containment efforts is the role the proposal preserves for the commercial medical care insurance industry. As we have noted, the profit-making and administrative chaos caused by the 1,200-1,500 medical care insurance companies is one of the major reasons for the current excessive cost of the U.S. health care system. By permitting private insurers to own and operate accountable Health Plans the Clinton proposal virtually insures a higher cost for the system. A study in September 1993 by Marion Merrell Dow found that 21 of the 25 fastest growing 105 were for-profit enterprises and that the "big eight" among insurance companies (Blue Cross, Cigna, Aetna, Travelers, MetLife, Prudential, Humana and United Health Care) owned 251 (45 percent) of the 562 105 in the country. The Clinton proposal, in other words, will leave a large part of the system in the hands of those who have engineered its current failure.

Equitable Financing: The Clinton proposal concentrates on a premium based employer mandate, reductions in the rate of growth of Medicare and Medicaid spending, increased corporate taxes, and a tax on tobacco products. With the exception of the increased corporate taxes and the subsidies suggested for low-wage employers, this method of payment is highly regressive. Low- and middle-income families will be called upon to shoulder much more than their fair share of the costs. Furthermore, the opting-out of large employers, whose employees are likely to be at

lower risk for high medical care expenses, would defeat the idea of equitable risk-sharing.

THE SINGLE-PAYER ALTERNATIVE

The alternative plan widely-known as "single-payer" is based in large part on models used outside the U.S., particularly in Canada. This plan for has been introduced into the Senate by Paul Wellstone (S. 491) and into the House of Representatives by James McDermott and John Conyers (HR. 1200).

PNHP believes, based on extensive evidence including studies by the U.S. General Accounting Office and a recent report by the Congressional Budget Office on estimates of the cost of the health care proposals submitted to the 102nd Congress, that a single-payer plan would save in administrative costs alone over 10 percent of the cost of the medical care system, over $100 billion annually at current cost levels. A feature of single-payer that could help insure these savings would be a prohibition on the ownership of managed care plans by for-profit industries such as commercial insurance companies. The Wellstone Bill (S. 491) is therefore, PNHP believes, particularly worthy of support because its stringent restrictions on profit-making in the provision of medical care.

These savings would make possible the universal coverage the Administration seeks, including coverage for all the currently uninsured and underinsured including undocumented people and migrant workers, without cuts in current levels. of services to the poor or the elderly and without the need for additional revenues. Furthermore, a single-payer plan could, much more easily than an employer-mandate plan, be designed to distribute the cost burdens much more equitably in the population.

Under the Clinton proposal, states may opt for single-payer either state-wide or for a specific region. While this is an important provision if the single-payer concept is not adopted nationally, under the current proposal the state must obtain a waiver from the federal government for ERISA, Medicare, and rules on regional and corporate alliance participation. PNHP urges that, if single payer is not adopted nationally there should be an expedited waiver process if states want to pursue a single-payer option. Additionally, once granted a single-payer option, states should be allowed to improve on the benefits package and eliminate cost sharing.

Some critics of single-payer proposals note the failure of some current versions to reduce the practice of fee-for-service medicine, which is believed by many to lead to overtreatment and higher costs. PNHP therefore urges mechanisms to limit unnecessary treatment, both because such treatment may be dangerous to the patient and because the cost of treatment will be reduced. Some critics of single-payer are also concerned about the loss of worker jobs in the health insurance industry; while many of these workers are nurses and other health professionals who will find clinical jobs as health services expand, displacement for the majority of workers is certain to be difficult. PNHP therefore urges protection of workers in the health insurance industry who will lose their jobs, using re-training programs, assistance in obtaining other positions and a variety of other measures.

But the most important problem for "single-payer" is its perceived political liability because it is characterized by its opponents as "socialized medicine" and in the press as "government control of the health care system" and as requiring "higher taxes." Politics, rather than the substance of the plan, has in my view played the predominant role in the Administration's selection of its recommendations. Polls of the U.S. population, and even polls of doctors, show considerable support for the single-payer concept. Many members of the staff of the President's Task Force on Health Care Reform supported the concept. The task for the next few months is to make the widespread support for single-payer and the nature of its advantages over the Clinton proposal widely known.

The Future of the U.S. Health Care System Will Be Shaped by the Public Response to the Administration's Proposal

The Administration needs a successful outcome in health care reform, which was an important issue in the President's electoral campaign. Exceedingly powerful interest groups—the insurance industry, the pharmaceutical industry, the hospital industry, and organized medicine—oppose fundamental reform of the system. Other powerful interest groups—such as people over age 65, who want to make certain their Medicare benefits are not diminished, and military veterans, who want to protect their special medical care benefits in the Veterans Affairs medical system—will attempt to push their own agendas. On the other side, the forces organized in favor of equitable access to the poor and powerless are relatively weak and disorganized.

The hope for adoption of a single-payer proposal lies in the opinions of the great majority of the people of the United States, who know the system isn't working and

report in polls that they want change that will provide them with high-quality services at costs that will be controlled and will be equitably shared. Unfortunately many of those who want change have been convinced that their taxes are "too high" (despite the U.S. having one of the lowest tax rates in the industrialized world) and oppose any reform that will raise their taxes even though their private or their employer's out-of-pocket payments for medical care would be sharply reduced. Much work remains to be done to educate the public on the single-payer alternatives and their impact on access, quality and cost and on the fact that other nations provide as high or higher levels of quality of care than we do and enjoy much higher levels of population satisfaction at much lower cost than does the United States.

Finally, many of us concerned with public health note that the equitable and universal provision of high-quality medical care, even if it includes elements of preventive medicine, is only a small part of what is needed to promote and protect the health of our people. Much more important, we believe, are community-based public health services and, especially, improving the economic and social well being of the population. We point out that the U.S., with its vast gulf between rich and poor, along with one of the lowest levels of taxation in the industrialized world, has much to learn from other nations in dealing with this issue as well.

With regard to single-payer, the Atlanta Journal/Constitution on September 11, 1993 editorialized:

The case for a single-payer system is a strong one. The fight for it must be waged vigorously in Congress, even as the odds now stand heavily against it. It must remain a viable option for the day when a combination of national need and political courage make its implementation possible.

Many of us believe the national need and the political courage to enact single-payer exist today. PNHP, and I personally, will continue our efforts to help the Administration, the Congress and the public understand the flaws in the President's proposal and the need for a single-payer approach now to national health care reform.

Senator METZENBAUM. Our next witness is Patti Tripoli, representing the New York State Nurses Association. Ms. Tripoli, we are happy to have you with us.

Ms. TRIPOLI. Thank you. Mr. Chairman and members of the committee, I am Patti Tripoli, a registered professional nurse at Community General Hospital of Greater Syracuse in upstate New York. On behalf of the largest and oldest State nurses association, the New York State Nurses Association, I would thank you for inviting us to testify today on behalf of single-payer financed health care reform.

Nineteen years ago, I started to work at Community General Hospital because of my interest in providing nursing care to the people of my community. After 8 years, I had acquired expertise that I wanted to share with other nurses to be sure that the patients received the best care possible. At that time, I decided I wanted to stay as close as possible to the patients, and therefore I accepted a position as staff development educator at that same hospital. I did not choose to become part of a faculty of the nursing school because I felt that I would be more removed from direct patient care than I wanted to be.

In the past 11 years, I have seen my job change drastically. Initially, I could devote my time to teaching nurses how to improve their care for patients. However, that has now become a luxury that happens only on rare occasions. Much of my time is now spent teaching RNs, LPNs, nurses aides, and nursing unit secretaries how to fill out a myriad of forms.

Why does the hospital have me spend so much of my time this way? Because this is the only way the hospital has any chance of making sure that it will receive money, get paid for the care that it provides to our patients. About 25 percent of my time is spent making sure that other people know how to fill out the forms cor-

rectly. What is even sadder, in my view, is that my hospital has 2 other RNs doing the same type of work full-time and another 6 nurses doing this work part-time.

There are also 16 RNs and LPNs doing utilization review. These nurses work full-time reviewing patient records just to make sure that all the forms are filled out correctly so that Medicare, Medicaid, Blue Cross, and commercial insurance companies will pay the bills that we submit. Nurses, who would rather be spending time taking care of patients, must take the time to fill out these forms correctly.

This scenario is not unique to Community General. It is the reality in hospitals all across America. However, it is not the norm in hospitals in other countries. Health care reform such as Senator Wellstone's proposal for a single-payer universal health care program would change all this. Billions of dollars could be saved if we establish a single-payer system that guarantees everyone will have the health care they need. Thousands of utilization review nurses could return to patient care. All nurses could stop nursing papers and return to nursing patients.

The New York State Nurses Association believes it is time to stop the wasteful spending on administrative overhead and start spending all of our health care dollars that are so desperately needed for patient care. A 1991 study in New York State showed that $6 billion could be saved in New York alone if a single-payer system such as Senator Wellstone's proposal were a reality.

The Government Accounting Office and the Congressional Budget Office have likewise concluded that only the single-payer proposal offers the opportunity to save enough in administrative costs to finance health care coverage for all Americans.

Our national association, the American Nurses Association, has previously told you how the system succeeds so masterfully for some, yet continues to fail shamefully for all too many others. America's nurses believe it is time to frame a bold, new vision for health care. For the last 5 years, nursing has worked to develop a plan which encompasses the profession's best vision of a health care system for the future.

There are several key features of nursing's agenda for health care reform that are very similar to the provisions of S. 491. For any health care reform plan to be successful, it is critical that it not only addresses access to health insurance, but also access to health care services. A single-payer financing mechanism is one cornerstone of reform. Additional reform strategies must make services available where people live, go to school, and work. This means the health care system must be restructured to make health services available in all communities to all populations.

The health care system must be reoriented to emphasize prevention and primary care. Nurses working and living in our communities are a resource for such a reform system. A recent Gallup poll revealed that the vast majority of Americans, 86 percent, are willing to receive every-day health care services from an advanced practice registered nurse.

As the focus of health care delivery sites shifts from acute care institutions to community-based care, there has been and will continue to be an increase of hospital mergers and closures resulting

from an over-supply of hospital beds. While we acknowledge that this change is inevitable, policymakers and health care providers together must prepare for this change.

The ANA has been working very closely with the Department of Labor on its workforce proposal related to health care reform. It is important for Congress to develop an initiative that provides assistance to health care workers before they are displaced from their jobs and face possible unemployment. Health care reform proposals, including the single-payer model, raise critical workforce and employment issues. The single-payer model can offer the best opportunity to identify and fund educational and training programs to provide the health care workers needed in a reformed health care system.

Registered nurses are the Nation's single largest group of health care professionals and many of them will need retraining to appropriately deliver care in a revised health care system. It is essential that a retraining and redeployment plan be designed to facilitate that transition. This transition plan is outlined in my written testimony and it is critical.

In New York State, our single-payer finance bill, New York Health, includes a dedicated funding stream to be used for educating and training health care workers. It is important to recognize that nurses and other workers in the health care industry will need retraining. Certainly, there will be many new jobs in the health care system when capacity is expanded to serve those who currently do not have access to services. The single-payer system can offer the financial resources to provide sufficient qualified health personnel to ensure delivery of quality care.

Mr. Chairman, thank you very much.

Senator METZENBAUM. Thank you very much. Your entire statement will be included in the record.

[The prepared statement of Ms. Tripoli follows:]

PREPARED STATEMENT OF PATTI TRIPOLI, RNC, MS

Mr. Chairman and members of the committee. I am Patti Tripoli, RNC, MS, a registered professional nurse at Community General Hospital of Greater Syracuse in Upstate New York. Thank you for inviting us to testify today on health care reform.

The New York State Nurses Association is the only full service professional organization representing New York's registered professional nurses including staff nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists. NYSNA advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by working closely with the New York State Legislature and regulatory agencies on health care issues affecting nurses and the public.

Access to high quality, affordable health care is of concern to millions of Americans—not only to the over thirty-seven million who are uninsured, but to the growing number of currently insured who fear that changing or losing their jobs will result in loss of coverage or that skyrocketing costs will make their dependents' coverage or their own out-of-pocket health care costs unaffordable.

New York's registered nurses deliver many essential health care services in a variety of settings—hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice and in managed care settings. Nurses know first hand of the inequities and problems with our nation's health care system. Because we are there—twenty-four hours a day, seven days a week—we know all too well how the system succeeds so masterfully for some, yet continues to fail shamefully for all too many others.

Nurses see people on a daily basis who are denied or delayed in obtaining appropriate care because they lack adequate health insurance or are unable to pay for

care. These people often postpone seeking help until they appear in a hospital emergency department in an advanced stage of illness or with problems that could have been treated earlier in less costly settings or, more appropriately, prevented altogether with earlier treatment or prevention services.

Delayed access to needed care is associated with problems of increased morbidity and mortality as well as countless hours of lost productivity in the workplace. Infants and children, pregnant: women, the frail elderly, people with persistent health problems, rural and inner city residents and minorities are disproportionately represented among these most vulnerable uninsured groups. Their complex and diverse needs are not met by the existing system.

Nursing is concerned by the failures in our current health care system. More than two million New Yorkers have no health insurance and millions more are critically underinsured. Our health care systems are oriented toward expensive interventions to treat illness, rather than essential health services designed to promote and maintain health. As a nation, we have failed to develop appropriate ways to allocate available health care resources and services. Unfortunately, the burden of the reality of the failures of our health care system are disproportionately felt by vulnerable segments of our nation's population. This includes the very young, the very old, the poor, the illiterate and those who live in rural and frontier communities and low-income urban communities.

Nursing defines the health care crisis in terms of the need to restructure, reorient and decentralize the health care system in order to guarantee access to services, contain costs and ensure quality. Fundamental restructuring must occur because patchwork approaches have failed. Health care reform must be comprehensive and not limited to addressing only one or two components of the problem.

NYSNA's nurses are united in urging that the nation's health care system be cured—and cured NOW. We must reshape and redirect the system away from inappropriate use of the expensive, technology-driven, hospital-based models we currently have. A balance must be struck between high tech treatment and prevention. It is nursing's belief that the system must emphasize and support health promotion and disease prevention and show compassion for those who need acute and long-term care.

For any health care reform plan to be successful, it is critical that it address not only access to health insurance, but also access to health care services. The health care setting must be restructured and reoriented so that services would be available in schools, workplaces and community settings as well as in hospitals and providers' offices. Consumer access to health care services must be maximized. Consumer education must be prioritized to foster increased awareness of personal health and self care and to provide a greater capacity for informed decision making in selective health care services. In addition, criteria for outcomes of care should reflect the joint perspective of both the health care consumer and the health care provider.

Emphasis on preventive and primary care services is also crucial, because it means that consumers will have a relationship with a primary care provider including nurses, nurse practitioners, certified nurse midwives, etc., that begins when they are still well—so that disease can be prevented whenever possible and so that the provider will be able to intervene earlier, to minimize the severity of illness.

Nurses, including advanced practice nurses (nurse practitioners, clinical nurse specialists, nurse midwives, nurse anesthetists), are well-positioned to fill many of the current gaps in accessibility and availability of primary and preventive health care services. There are over 100,000 advanced practice nurses with advanced education and training in providing primary care services throughout America. As many as 300,000 additional nurses could be prepared to provide such services with additional training.

Virtually every study of patient care provided by providers other than physicians has concluded that these providers can deliver services of the same quality as physicians at lower costs. To meet the estimated additional sixty-four (64) million non emergency ambulatory care visits under a universal access health care system, 9,000 additional general and family practice physicians would be required at an office expense of $2.1 million. Alternatively1 less than 17,000 nurse practitioners could provide the same level of services at a similar level of quality for about $1.5 million, a savings of twenty-five (25)percent.

However, the ability of nurses to provide health care services has been continually hampered by a number of artificial barriers that serve to cut the consumer off from access to services provided by these competent and qualified health providers. These barriers include restrictive reimbursement policies by Federal and state programs and private insurers. They include irrational restrictions on nursing practice such as physician supervision requirements by laws and regulations at the state level. We have a Medicare program that denies payment for needed health care services

by nurse practitioners or clinical nurse specialists in non-rural areas, including underserved urban areas. The laws regarding reimbursement for advanced practice nurses are complicated and convoluted as to which categories of advanced practice nurses may be reimbursed, in what geographic areas, who may be paid and whether or not collaboration with other health providers is required. They are confusing and complex enough, to carrier, provider and consumer alike, as to provide a barrier to access to these services in and of themselves. In addition, the New York state Medicaid program denies reimbursement to clinical nurse specialists, even when they are the only providers willing to furnish services to underserved Medicaid recipients.

Laws and regulations in New York state put unneeded restrictions on the practice of nurses, including advanced practice nurses. These barriers prevent nurses from providing services such as routine care and medications, billing insurance companies, operating a private practice, obtaining clinical privileges or admitting patients to a hospital. The state's restrictions on prescriptive authority for advanced practice nurses is another barrier to health care and promotes the costly use of an additional provider.

Just as nurses throughout the United States have demonstrated their ability to provide high quality, cost effective and accessible health services, consumers have shown their widespread acceptance of these services and their willingness to continue receiving primary care services from nurses. A recent Gallup poll revealed that the vast majority of Americans (86 percent) are willing to receive everyday health care services from an advanced practice registered nurse that they now must go to a physician to receive. Only twelve (12) percent said they would be "unwilling" to go to a registered nurse. Nurses are currently working with consumer-oriented organizations in order to promote shared principles of health care reform.We are confident that as the American public becomes more familiar with the primary care services that nurses can provide, and as more Americans have an opportunity to receive such care from nurses, that the "unwilling" category will decrease sharply. In fact, we believe that, based on the experiences of advanced practice nurses in HMO, clinic, and private practice settings, more and more Americans will identify nurses as their provider from whom they select to receive primary care services.

QUALITY ISSUES

As health care reform becomes a reality, hospitals and other health care institutions will experience increasing pressure to contain costs. As the focus of the health care delivery site shifts from acute-care institutions to community based care, there will be an increase of hospital mergers and closures of hospitals resulting from an oversupply of beds. It is anticipated that some hospitals will specialize and others will integrate services such as home health and nursing homes.

Nurses have had an opportunity to experience first-hand what many hospitals do when they face pressure to cut costs. In the last few years, nurses have grown increasingly alarmed at the wholesale reduction in quality of care that many hospitals have initiated in the name of cost-savings and cost-efficiency. Numbers of nurse positions have been cut and nurses have been laid off. In their place, hospitals have hired unlicensed, semi-skilled personnel, often trained by the hospitals themselves in brief training courses. While the use of unlicensed personnel to assist registered nurses is not new, hospitals in the last few years have greatly expanded the use of these personnel, both in numbers and in the range of functions they perform. This has happened at a time when, due to a number of factors, the severity of illness of the hospitalized patient population has increased significantly. As a result, registered nurses find themselves caring for and supervising care for ever greater numbers of increasingly sick patients. This has meant a continual downgrading of care for patients, one which poses a real risk to their health and safety while hospitalized.

Many hospitals have openly stated-threatened, if you will-that they will increase the trend toward downward substitution if health care reform is enacted. We consider this not only a threat to nurses, but also to the patients we care for patients who literally entrust their lives to the hospitals. We believe that hospitals must adhere to strict quality controls if patient care is to be protected. Hospitals should not be permitted to sacrifice patient care in the name of cost efficiency. We believe there must be mechanisms to protect and ensure safe, quality care both in the long run and in the period of transition to a reformed health care system. These mechanisms must include the development of patient outcome measures as well as, in the immediate period, criteria that monitor changes in hospital staffing and patient care delivery patterns to ensure that patient care is not compromised.

THE HEALTH CARE WORKFORCE

Critical workforce issues are raised by any health care reform plan regarding its effect on employment. Within the health care industry, the impacts will be based on the types of jobs individuals hold. Nurses are the single largest groups of health care providers. It is estimated that fully two-thirds of the nation's registered nurses will need to be retrained to appropriately staff a revised health system. Although we are optimistic that nurse displacement will be short term, it will be essential that a retraining and redeployment plan be designed to facilitate that transition. Nursing believes that the transition plan must include a series of interim quality protections that safeguard patient care and provide for re-training and re-deployment of health care personnel. The decision of hospitals and other institutions to significantly alter staffing levels, mix or re-ploy personnel should be guided by several basic principles:

—Advanced public disclosure of the intention to merge, close, or significantly redeploy personnel;

—Involvement of consumers and affected professional personnel in development and implementation of educational programs and other means for re-deployment;

—Evaluation and report to health care consumers;

—Analysis of the impact of the re-deployment on patient outcomes and other quality care indicators; and

—Assurance that re-deployment plans use professional personnel in accord with licensure laws, educational preparation and assessed competence.

In addition, a national transition plan for the health care workforce should contain, at a minimum:

—Retraining and relocation programs to prepare personnel to assume positions in primary health care, public health, and critical care across a variety of health care delivery settings;

—Use of conversion boards to assess the opportunity for the hospital or institution to be converted to some other use in order to keep the jobs in the community;

—Institution of training programs on "How to Start a Business" and access to small business loans in order to encourage nurses and other providers to establish small community health care clinics to benefit their communities;

—Pre-notification to providers and the community of any hospital closure or merger;

—Continuation of health and pension benefits for health care personnel;

—Continuation of HIV disability coverage;

—Limits on discounting health care services to prevent cost shifting; and

—Annual public reports about the impact of major institutional changes in staffing levels, mix, or deployment on the quality of care delivered.

The situation of a re-focused health care workforce must be monitored very carefully throughout the transition period and into the enactment of health care reform. Should there be significant increases or changes in morbidity or mortality rates or increases in adverse occurrences (i.e., falls, infections, medication errors) or other indicators of change in the quality of care in hospitals, then more aggressive steps to ensure quality patient care will need to be enacted such as a decertification or fine system for hospitals not complying with quality standards.

Nursing cautions, however, that training opportunities envisioned for low skilled workers in the health care industry (clerical and administrative support positions) may inadvertently increase the pool of another group of low skilled workers (such as nurses' aides, nursing technicians, nursing assistants). Nursing is concerned that any emphasis on short-term and on-the-job training as well as the use of the term "higher value added health care jobs" without defining such jobs will increase the number of low skilled health care providers. This goal neither meets the health care needs of the nation, or is in the best interest of these workers, most of whom are women. Rather, increasing the pool of professional health care providers is critical.

Another issue associated with a decreasing demand for hospital based nurses is the possible decline in nursing wages. To minimize this downward pressure on wages, the current and future supply of nursing labor must be channeled away from settings with decreasing demand and into higher growth areas. To maximize nurses' earnings and avoid serious imbalance in the supply and demand for nurses, a specific plan to systematically assess, manage and evaluate the recruitment, education and utilization of nurses is needed.

NURSING EDUCATION

Health care reform will require a refocusing of knowledge and skills for nursing faculty and future nurses. With greater emphasis on prevention and early intervention, as well as a decreased need for acute care nurses, nursing education will need

to be re-focused on primary health care and the management of acute minor illness and complex chronic diseases. Skills in case management, discharge planning, supervision of health personnel, and financial planning will be essential. Fortunately, many nurses are skilled in these vital areas, but many more will be needed.

The trend that will occur in a health care reform environment which is of most significance to nurses is the shift in balance between episodic, high cost, specialty focused, hospital based tertiary care to primary and preventive care delivered in a range of ambulatory care settings by a variety of practitioners. This shift is already occurring, as witnessed by the rapid growth in home care and ambulatory care services.

Since World War II, the majority of nurses have been educated for and employed in hospitals. Significant educational efforts on both the part of individual nurses and the health system are now needed to focus on the delivery of primary health care services. To fund nurse education, new programs need to be established to increase the supply of nurses prepared to work in primary care.

According to the National Sample Survey of Nurses (1988), there are approximately 125,000 registered nurses working in physician offices, freestanding clinics, ambulatory surgical centers, health maintenance organizations and other ambulatory care settings. In addition, there are approximately 11,000 registered nurses working in community/public health settings, 48,000 in school health, and another 22,000 in occupational health. With the appropriate funding support, this pool of generalist nurses could begin to rapidly increase the nation's supply of primary care providers.

The American Nurses Association has specifically recommended that an amount equal to 10 percent of direct Graduate Medical Education (GME) funds be used in a manner similar to that used in the GME program for physicians. The funds would be allocated to support the education and training of primary care nurses and specialty advanced practice nurses, such as certified registered anesthetists. The funds would enable hospitals to maintain quality service and cost effectiveness. Because of the importance of advanced practice nurses to the delivery of care, a constant stream of dollars is needed to support the education and training of these providers on a basis similar and equal to resident physicians. Nursing believes that this fund must be in addition to the current Nurse Education Act program.

Funds are needed to develop retraining opportunities for nurses who are forced to leave the tertiary care workforce for community, primary and preventive care practice areas including post-master's certificate programs to enhance the primary care skills and abilities of clinical nurse specialists and other master's prepared nurses. BSN programs will need to be expanded to assist the diploma and associate degree nurses employed in acute care settings to rapidly obtain a BSN in order to enhance their community, public health and/or critical care knowledge and skills. In addition, hospitals will need assistance to provide continuing education to acute care nurses for acquisition of community care nursing skills. These BSN assistance programs and continuing education programs are essential in order to prepare nurses to make the transition from hospital to community based nursing care.

In addition to preparing primary care providers and other nurses, it is also of importance to ensure that there is an adequate supply of nurse educators, both at the undergraduate and graduate levels of education. Existing nursing faculty may need additional training themselves in order to become nurse practitioner and other advanced practice nurse educators.

Nursing strongly supports increasing the cultural diversity of the health care workforce by supporting programs aimed at under-represented ethnic, minority and/or disadvantaged persons. Such efforts are needed to recruit and retain students to nursing and other professions and to increase the number of minority faculty and researchers in the health professions.

RESURGENCE OF THE PUBLIC HEALTH SYSTEM

Increased funding for public health programs at a state level is critical to the future health and well being of a diverse population. The original mission of public health programs must be restored to focus on community prevention rather than direct delivery of health services. Core public health activities as data collection; surveillance and monitoring; protection of the environment, housing, food, and water; and disease investigation and control must be restored and expanded.

There is a need for a strong public information and education component to mobilize communities and motivate individuals to reduce risks to health. Nursing stands ready to lead community and individual efforts to reduce some of our deadliest and costliest health risks—tobacco use, drug and alcohol abuse, sexual activity that increases the prevalence of HIV infection and other sexually transmitted diseases, in-

adequate or poor nutrition, physical inactivity, and the lack of childhood immunizations.

ADMINISTRATIVE SIMPLIFICATION AND COST SAVINGS

Nurses throughout the nation breathed a collective sigh of relief when the President outlined the need to simplify the mounting paperwork and other administrative requirements that burden our health care system. We know firsthand what a waste of professional time these requirements can represent. Too often, nurses are forced to take time away from patient care and devote it to filling out forms. It has been estimated that a staff nurse fills out an average of 19 forms per patient. Thus, NYSNA advocates the single paper proposal as the most effective way to pare down and simplify paperwork and other wasteful administrative requirements.

However, we need to draw a distinction here between completion of insurance forms and other activities that serve little other than facilitating the flow of paperwork and bureaucracy, and efforts that do facilitate maintaining and improving quality and patient care standards. We need enhanced data collection that is related to quality of care, development of outcomes criteria and other activities that are directly relevant to patient care. As health care professionals, we regard this as important and necessary. The distinction we make is between needless and endless paperwork and the collection of patient care information that leads to continuous improvement in the quality of care. We are more than happy to give up the former and opt for the latter.

CONCLUSION

Mr. Chairman, we commend the Committee for holding this hearing and for working so diligently to find solutions to the health care crisis. We appreciate this opportunity to share our views with you and look forward to continuing to work with you as comprehensive health care reform legislation is developed. Thank you.

Senator METZENBAUM. Our last witness on this panel is Dr. Konner. Dr. Konner is from Atlanta, GA. We are very happy to have you with us, sir. Please proceed.

Dr. KONNER. Thank you. My name is Melvin Konner and I have an M.D., as well as a Ph.D. in anthropology. To my mother's regret, I don't practice medicine, but teach and write about medicine and society. I understand the viewpoint of the practicing physician, but get no part of my income from the delivery of care. I am listed as a provider on your docket, but that is actually not right.

By the way, I hate the word "provider." I don't see why we can't call people caregivers or health professionals. I think "provider" is actually——

Senator METZENBAUM. Would your mother like to testify on the second panel? [Laughter.]

Dr. KONNER. I think the word "provider" is actually a way of insulting nurses, doctors, and other caregivers.

I have to part from my text because when Senator Wellstone mentioned micromanagement I was reminded of this time at Beth Israel Hospital in Boston when I was in medical school. My beeper woke me up at 5:00 a.m. and I ran up three flights of stairs to be part of a team resuscitating a very unfortunate 83-year-old lady who was dying of lung cancer and was also demented. I was literally breathing for her with a hand-operated breathing bag when I realized there was some commotion among the residents, and I asked a few questions and found out that the chief resident, the young doctor who was the chief resident, was on the phone with the hospital's lawyer, who was on another line with the lady's nursing home's lawyer to find out if the resuscitation had to continue. Talk about micromanagement, but it did continue and she had no next of kin, so that lawyer made the decision. I thought to myself

as I continued, well, at least the lawyers are also up at 5:00 a.m. [Laughter.]

That kind of micromanagement not only by lawyers, but by bean-counters and phone jockeys and other representatives of the insurance companies has become far, far more common than it was then.

Due to serious illness in my family, I also know how it feels to be at the other end of the stethoscope, so it is a privilege for me to have your attention even briefly.

President Clinton asked us to let six basic values and principles guide our efforts—security, simplicity, savings, choice, quality, and responsibility. I agree, but argue that his plan will not meet these goals, while a single-payer system will.

Security: This means universal coverage phased in over 5 to 7 years, but his plan preserves the outmoded link between employment and health care, so weakens the security of those who change jobs or retire early. It allows large companies to opt out of the system, giving them almost complete control over their employees' health care, and it leaves serious questions about how rural America will be covered.

Single-payer ensures security for every citizen through an agency appointed by State government. Job status has no bearing, so no inertia in the labor market results from fear of reduced benefits, and there is no delay while millions of vulnerable small businesses buffer themselves against the shock of an employer mandate.

Simplicity: The Clinton plan adds several new layers of bureaucracy. Single-payer is simply that, a single agency at the State level that pays for all health care—no duplication of effort, no middleman, no profits for corporate giants. Doctors remain independent and patients free to choose. The difference between the 24 cents on the health care dollar that we spend on administration and the 11 cents that Canada spends—13 cents simply thrown away—would cover the uninsured.

Savings: Economists across the political spectrum have challenged the prospect of savings under the Clinton plan. The Health Care Financing Administration estimated that such a plan would add between $100 and $150 billion annually, an increase of 10 to 15 percent. Single-payer costs far less. Serious projections range from an 8-percent decrease to a 5-percent increase. The General Accounting Office projected a decrease of 0.4 percent.

Choice: Under the Clinton plan, Americans will be urged into managed care plans, each offering only a narrow choice of doctors. A study in the Journal of the American Medical Association in August surveyed 17,000 patients in 3 cities. Between 62 and 69 percent of the patients who saw doctors in small offices—that is, independent practices—rated their own care as excellent, but for HMOs excellent ratings were much lower, 37 to 55 percent. "Patients bounce around in these systems," one of the researchers said. "It is the dark side of managed care."

Single-payer leaves the patient's choice of doctor completely open. There are no networks to join, no private insurance plans to weigh against each other, just the traditional doctor-patient relationship functioning in an open-market context. Single-payer is not socialized medicine. British and Canadian medicine do not resemble each other. In a Harris poll, 97 percent of Canadians said they liked

their system. Single-payer combines some of the best conservative values—freedom of choice among doctors who are independent entrepreneurs, and effective cost control—with the liberal goal of universal coverage.

Quality: We hear that America has the world's best health care, but managed care plans have already lowered its quality. Under the Clinton plan, new tiers of bureaucrats micromanage the doctor-patient relationship. Doctors lose authority and patients lose confidence, while insurers gain a great deal of money. Single-payer allows for national guidelines, but interferes much less with the doctor-patient relationship. It also helps rectify the imbalance between front-line primary care and high-tech specialty care that plagues our system today. Over-treatment is costly, painful, and dangerous, and is far from synonymous with quality.

Responsibility: The Clinton administration attempts to achieve this with copayments, but disincentives for timely care only increase costs down the line. Americans have improved their health habits. Education and prevention programs, with the recognition of the value of time in the doctor-patient encounter, will strengthen this trend.

Conclusion: Only one function is served by the Clinton plan that is not better served by single-payer. It preserves the market position of the insurance business giants. For-profit insurers don't lance a boil, vaccinate a child, take out an appendix, or comfort a grieving relative. Yet, theirs has been the decisive voice in reform which will bring them vast windfall profits. They are now moving aggressively into medical care itself and may soon have a vertical monopoly on America's health care.

Under single-payer, the for-profit insurers would be out of the health business. Then perhaps we would see that health care was never a business in the first place. It was and is a public good to be managed as a public trust. Single-payer would give us independent doctors and public financing, neither the nationalized medicine of the British nor the imaginary markets of managed competition, but the best compromise between professional entrepreneurship and community responsibility.

The health care crisis is a major illness. Managed competition is aspirin and a band-aid. When America calls in the morning, it will be in greater pain. It urgently needs a more sensible, serious, and informed intervention, not the minor tinkering of managed competition. Why not simplify health reform, the single-payer proponents have asked. Why not indeed simplify, democratize, and while we are at it keep our free choice of doctor?

Thank you.

[The prepared statement of Dr. Konner follows:]

PREPARED STATEMENT OF MELVIN KONNER, M.D.

My name is Melvin Konner, and I teach human biology and medical anthropology at Emory University in Atlanta. I hold Ph.D. and M.D. degrees from another noted institution of higher learning where, after six years on the faculty, I attended medical school. You may well imagine my mother's disappointment when, upon getting my M.D., I went back to being a professor again. But I thought I had more to offer as an observer of the relationship between medicine and society than as a practitioner. I have authored three well-received books on this relationship, and have taught for many years about it. I understand the viewpoint of the practicing physician, but I get no portion of my income from the delivery of care, and so have no

special interest in the economic results of reform. Due to some serious illnesses in my immediate family, I also know how it feels to be on the other end of the stethoscope.

My testimony reflects only my own opinion, not that of any institution or organization. However, I revere the institution that you represent, and I consider it a privilege to have your attention even briefly. As I have told some of my more cynical students, if you don't believe in the United States Senate, you don't really believe in democracy. I know it would do you no service for me to be less than frank, and I hope and trust that you will take my frankness as a sign of respect. I do not think that health care reform is nearly as complex as it has been made to seem The American people are confused by the Clinton proposal, as we all are if we are honest. This confusion is not inherently necessary.

In his speech on September 22, President Clinton told us that "every successful journey is guided by fixed stars—basic values and principles" that "must embody our efforts to reform America's health care system: security, simplicity, savings, choice, quality, and responsibility." Taking him at his word, I will look at how well his proposed reforms—as far as we can understand them in the absence of actual legislation—steer by these stars. More importantly, I will try to show you that another vessel on these rough waters, the good ship Single Payer, has reckoned a truer course by the same six stars.

Security: By security President Clinton means universal reliable coverage. In his speech to the Governors in August, he predicted a five to seven year delay in achieving this goal. Among those who wait will be millions of hard-working people and their children—people working on farms and in building trades, in repair and service businesses, all of whom deserve better. The plan preserves the outmoded link between employment and health care, and so jeopardizes the security of those who change jobs or retire early, even though some effort will be made to cover them. It allows large companies to opt out of the health alliances, giving them almost complete control over their employees' health care. And it leaves serious questions about how the one-third of Americans living in rural areas, where managed competition cannot work, will be covered. The benefits package looks good, but cutbacks are likely as a handful of giant insurance firms assess their market position and consider the needs of their stockholders.

Single payer plans ensure security straightforwardly. Every citizen is covered by an agency appointed by state government. Employment status has no bearing on coverage, and so no inertia in the labor market results from fear of lost or reduced benefits—that is, there is no "job lock." Since there is no employer mandate, there is no need to let years go by while millions of vulnerable small businesses buffer themselves against the shock of such a mandate.

Simplicity: This where the two approaches differ most strongly. The Clinton plan will add several new layers of bureaucracy, including a National Health Board, purchasing cooperatives called Health Alliances, and various county and state entities that will vie for administrative aegis. Doctors and patients will have hospital bureaucrats looking over their shoulders, while managed care bureaucrats look over theirs, while insurance company bureaucrats look over theirs, while the National Health Board looks over theirs.

Single payer is simply that: a single agency at the state level that pays for all health care. No duplication of effort, no middleman, and no profits for corporate giants. Doctors remain relatively independent and patients remain free to choose. The difference between the 24 cents on the health care dollar that we spend on administration and the 11 cents that Canada spends—13 cents simply thrown away—would suffice to cover the uninsured.

Savings: Cost control is high on every list of priorities, since America's long-term commitment to health care and its international competitiveness are jeopardized by health care hyperinflation. I will not dwell on the difficulty of achieving savings under the Clinton plan, since economists across the political spectrum have challenged the likelihood of savings anywhere near as large as those the administration is expecting. The Health Care Financing Administration itself, in early May 1993, estimated that a plan like the one introduced by the Clintons would add between $100 and $150 billion annually, an increase of 10 to IS percent, if the uninsured are really to be covered.

Single payer will achieve that goal at much lower cost. An April 1993 Congressional Budget Office Staff Memorandum reviewed four different serious estimates of the change in our nation's health expenses under a single payer system. They range from an 8 percent decrease, estimated by Physicians for a National Health Program, to a5 percent increase, estimated by the Congressional Budget Office itself. The General Accounting Office projected a decrease of 0.4 percent and an independent research group publishing in Health Affairs, a 4.2 percent increase. The

cost of the transition to the Clinton plan is at least twice that of moving to single payer, and possibly much more.

Choice: Under the Clinton plan, choice will decline dramatically. Americans will be herded into managed care plans like HMOs and PPOs, each of which will offer only a narrow choice of doctors. The idea is a simple one in terms of profits. Managed care, the bread and butter of the new breed of insurers, isn't profitable unless you have administrative efficiency. That means not having to deal with a large number of different doctors' offices, with their different procedures and personnel. And that in turn means little or no choice. Patients in these plans are very dissatisfied. A study published in the Journal of the American Medical Association on August 18,1993 measured the ratings given by over 17,000 patients in three different cities to small doctors' offices, large medical practices, and HMOs. Between 62 and 69 percent of the patients who saw doctors in small offices rated their care as excellent. These are the kinds of practices that the Clinton plan will gradually eliminate, as health alliances gobble up all the patients and structure incentives to favor large health plans like HMOs. Yet for HMOs in the study, excellent ratings were much lower, ranging from 37 to 55 percent. "Patients bounce around in these systems," one of the researchers said. "It's the dark side of managed care."

HMO patients wait a long time for a short appointment. Patients of independent doctors—the kind most of us will be unable to afford under the Clinton plan—were much more satisfied with their doctor's explanation of the illness and its treatment. Most important, they were more likely to feel that their doctor cared about their well-being. The main effect of the Clinton plan will be to urge vast numbers of Americans who now see independent doctors into HMOs. Few independent doctors will be able to survive. Meanwhile their Canadian counterparts will be going about their work in relative freedom, with a level of earnings that rewards them fairly for their hassle-free professional activities.

Single payer leaves the patient's choice of doctor completely open. It is just that simple. There are no networks to join, no private insurance plans to weigh against each other, just the traditional doctor-patient relationship functioning in an open-market context. Single payer is not socialized medicine. British and Canadian medicine do not resemble each other. Single payer combines some of the best conservative values—freedom of choice among doctors, who are in turn independent entrepreneurs, and effective cost control—with the liberal goal of universal coverage, by rationalizing the process of payment.

Quality: President Bush used to say that America has the best health care in the world, and we mustn't jeopardize it. President Clinton modified this to say that for those who have access, America has the best care. Neither statement is true. Managed care has hurt quality, with long waits for short visits and poor doctor-patient relationships. In addition, overtreatment is rampant in America, with Rand Corporation and other studies showing tens of thousands of unwarranted coronary' bypass operations, pacemaker implantations, caesarean sections, hysterectomies, prostatectomies, and other major surgeries every year. Overuse of invasive diagnostic procedures is also widespread, and unnecessary tests in general probably number in the millions. Aside from their cost, these procedures are uncomfortable and dangerous. Overtreatment compromises the quality of care almost as much as does undertreatment. Comedian Milton Berle used to say that one of the amazing things about doctors is that they cure poor people faster. Today, if the poor are uninsured, they may not get cured at all, while if they are covered by Medicare or Medicaid they get cured just as slowly and just as expensively as rich people. The Clinton plan does little to reduce incentives for overtreatment.

Single payer allows for the widespread application of national guidelines for treatment, and for a national bank of data on treatment outcomes. If experience in other countries is any guide, it will also ensure that our current grotesque imbalance between prevention and intervention, and between front-line primary care and high-tech specialized care, will be rectified.

Responsibility: This is a goal that must be reached by any working health care system. The Clinton administration attempts to achieve this with copayments. Single-payer advocates, who tend to have a deep understanding of the role of prevention, realize that there must be no disincentives for timely care—they only increase costs down the line. Americans have shown a clear willingness to improve their health habits over the past three decades, and a marked reduction in the rate of heart disease has resulted. I believe that an appropriate increase in funding for educational and preventive medicine programs, together with a recognition of the value of time in the doctor-patient encounter, will serve to augment further Americans' sense of individual responsibility for health.

Conclusion: The Clinton plan serves all these goals less well, and the most important ones far less well, than does the single payer bill (S. 491) introduced in the

Senate by Paul Wellstone of Minnesota. There is only one function served by the Clinton plan that is not served by single payer: it preserves the market position of the insurance business giants. They extract hundreds of billions from our national health care fund. In return they offer inefficient administration and harassment of caregivers. In other countries without for-profit insurers, this administrative job is done by a far smaller corps of people, for no purpose except the public good. For-profit insurers don't lance a boil, vaccinate a child, take out an appendix, or comfort a grieving relative. Yet theirs has been the decisive voice in the Clintons' reform process, which will bring them vast windfall profits.

In theory, each local region will have several health alliances that will force insurance plans to compete for their business. In reality only the largest and best capitalized of insurers will be able to compete. The five largest companies have voted with their feet: they have split from the Health Insurance Association of America to form the Coalition for Managed Competition. An executive vice president of Prudential said in the company newsletter recently, "For [Prudential] the best-case scenario for reform—preferable even to the status quo—would be enactment of a managed competition proposal."

This handful of businesses is moving aggressively into the delivery of care itself. Prudential, Metropolitan Life, Cigna, and Aetna have each acquired HMOs and other managed care companies that enroll millions of people. As Kenneth S. Abramowitz, an industry analyst, put it, "I envision the insurance companies transforming themselves into HMOs or getting out of the business." This is likely to result in a vertical monopoly on America's health care.

Under a single payer system the for-profit insurers would be where they belong: out of the health business altogether. Then perhaps we will be able to remember that health care was never a business in the first place. It was, and is, a public good, that should be managed as a public trust. What we really need is what the Canadian plan would give us: independent doctors and public financing—neither the nationalized medicine of the British nor the imaginary markets of managed competition, but the best compromise between professional entrepreneurship and community responsibility.

The single payer concept is the crest of a breaking wave of real reform. It is now supported by 89 Congressmen and women, five Senators, Consumers Union, Ralph Nader's Public Citizen, Citizen Action, the New England Journal of Medicine. the American Public Health Association, 5,500 members of Physicians for a National Health Program, the American Medical Student Association—as usual, far ahead of their elders in the profession—the Interreligious Council on Health Reform, The New Yorker, The Atlanta Journal-Constitution, and labor organizations from the Screen Actors Guild to the Ladies' Garment Workers. This is not the wave of the future, but of the present.

We hear again and again the claim that single payer systems are politically unacceptable. Once, the progressive income tax was politically unacceptable. Social security, integration of the armed forces, Medicare, voting rights—all politically unacceptable. If we let the most timid among us blaze our paths to the future, we would still be lost in a nineteenth century jungle, trying to find a clearing for child labor laws and the regulation of slaughterhouses.

The current health care crisis is a major illness. Managed competition is aspirin and a bandaid. When America calls in the morning it will be more fundamentally ill and in even greater pain. It urgently needs a more sensible, serious, and informed intervention—not the minor tinkering of managed competition—tinkering that leaves the greatest inequities and waste of our present system largely intact. In Canada, payment is government-regulated; medicine is private, doctors independent, and patients free to choose. We've heard that the Canadian plan would give us the compassion of the IRS and the efficiency of the post office. More likely, it would be the prices of the post office and the efficiency of Norman Schwartzkopf's army—good enough for government work or any other sort of work. As for compassion, it would be hard for us to do worse than we do now.

The Administration has proposed a system that will take away our choices, and one in which cost control will amount to squeezing balloons. We do not have to think that single payer would be perfect to think that it would do better than that. And by the way, if the Post Office had the same efficiency as our present health care system, thirty-seven million of us would never get any mail, and 60 million would only get it sometimes.

The Clinton plan is a Rube Goldberg machine—a cartoon apparatus that used to depict things like, say, a lever kicking a boot, which wakes up a cat, which runs on a treadmill, which pulls a trigger and fires a bullet, which pops a balloon, which turns a watering can, so that a flower can perk up and tip a platform that—well, you get the idea. At the end of these farcical sequences, Goldberg, an engineer-

turned-cartoonist would have the apparatus serve its ultimate purpose—something like switching on a light bulb. "Why not simplify health reform?" the advocates of a single payer have asked. Why not, indeed? Simplify, democratize, and while we're at it, keep our free choice of doctor.

Thank you for your generous attention to my views. I will be happy to answer any questions.

Senator Wellstone [presiding.] Thank you very much.

Senator Jeffords.

Senator JEFFORDS. I just have one question. My State is looking at single-payer, and it is also looking at the options provided under the Clinton health plan. The Clinton health plan, as you know, allows the State the option of a single-payer. Why isn't that enough?

Dr. KONNER. Well, I think there are a lot of complex issues in legislation regarding the waiver of certain mandatory participation in elements of the Clinton plan. I think it is very important that States be allowed to make that choice, and I think some States will and if the experience in Canada is any guide, that may be the way single-payer finally comes to America because of the pioneering efforts of individual States. But I think it is important that the Clinton plan make that not too difficult an option, and I think it would be better if the country as a whole decided to go in that direction right at the beginning.

Senator WELLSTONE. I wonder, Senator Jeffords, if I could just add to this, and maybe we could hear from other people as well. I think I like the direction you are going in, where a lot of people are saying let us have a level playing field and, you know, let us look at what some different States can do as we move along.

Right now, unfortunately, the devil is in the detail and if you have a lot of waivers and a lot of hurdles to go over and, in addition, there is a real restriction as to how the States can finance their health care, then you are not really offering States a real alternative. We need language that clearly will enable States to make this choice. I think if we do that in such a way that States can do it, it is fine. Right now, I think unfortunately there are just entirely too many waiver problems. I think we are all working on this right now.

Dr. INDIHAR. Senator, in Minnesota where we are working on the managed care plan, there is an all-payer system as an alternative. The details are not worked out with that. However, it seems as though this plan would be punitive to try to force patients into the collectives and physicians into the collectives and not remain in the all-payer or single-payer system, as they are envisioning it. So they are looking at it as being punitive to remain there. If you want to remain independent and remain having autonomy, there would be a punitive system with lesser care.

Senator JEFFORDS. Punitive in what sense?

Dr. INDIHAR. Punitive reimbursement, punitive with regard to choice of hospital or system, having less reimbursement for physicians, less choice of patients to go to various hospitals, etc, than would be available in the managed care plans.

Senator JEFFORDS. Dr. Sidel.

Dr. SIDEL. In working with people working on single-payer alternatives in New York State and Vermont and other States, they are discouraged, sir. They are discouraged by all of the barriers that exist to attempting to do single-payer on a State-by-State basis. It

is up to the Federal Government, if I might suggest, Senator, to give us a signal to say that this is the plan that will give the best care at the best cost with the most simplicity to the United States, and not to wait for the States to do it. The responsibility, if I might suggest it, sir, is yours to lead the way.

Senator JEFFORDS. Patti.

Ms. TRIPOLI. I just can't imagine that with having an option that we would be able to eliminate the administrative and overhead costs and confusion that results from the multipayer systems that we have today. If we are going to try to reduce those costs and reduce that confusion, then single-payer would do that the best.

Senator JEFFORDS. Thank you.

Senator WELLSTONE. Senator Jeffords, thank you for being here. That is something we should probably talk about because I am interested in this question of States having the option.

Just one clarification, not to take issue with what has been said, but I think that if, in fact, you could get beyond all of the waiver problems that exist right now and the clear signal was that States clearly could go ahead and design and implement their own plans, then States could really have to decide to have a single-payer system. You could then have that bargaining process. Of course, the package of benefits is set at the Federal level, but it is within a Federal system. So the designing, implementing, bargaining, and creativity happens at the State level.

I can't speak for other people on the single-payer front, but I know at least what some people have said to me. To go back to that Citizens Jury, people who were hearing about this for the first time were saying why not at least have a level playing field and let us let States become the laboratories of reform and let us see what happens; that is, Dr. Sidel, without putting up the hurdles before people. I think that may be a place where we go, but we have to make sure, in fact, that that can be done.

I would like to, first of all, address, Patti, if I could—could you talk a little bit about how you think a single-payer plan, whether designed at the pure national level or in the State of New York or any State—how would that affect nurses, nurse practitioners, and other people that are providing primary care? Do you think that that would better enable you to practice the kind of care that you think nursing is all about, as compared to, if you will, the, quote, "managed competition" framework? I mean, are there clear differences?

Ms. TRIPOLI. I am not sure about the total differences. I know that with multipayer programs, the confusion of the paperwork and the need for the paperwork to document what is needed to be there is what gets to be the difficulty. We want to be able to see and care for our patients and spend time with them.

Senator WELLSTONE. I guess the question I am asking is do you have any—this was brought up by Dr. Konner as well—do you have any difficulty, as you see it from the point of view of nurses, with the role of the insurance industry right now in terms of your delivery of care to people? I mean, you are so down in the trenches, I guess what I am trying to get you to do is to really talk about it in human terms.

Ms. TRIPOLI. Very definitely, there is a problem, one of providership. I have a license to practice nursing and there are a variety of things that I can do as a nurse, but because the insurance company says that only a physician can provide that service, I am not able to do that. Yet, there aren't always the physicians available to do that, and we have seen in history that nurse practitioners and nurse midwives are willing to go out and serve in the underserved areas.

Medicare pays for a portion of these services, but on a whole the insurance industry does not recognize the role of a nurse as being a competent health professional that could make an alternative, and therefore increase access to health care, as well as reduce costs.

Dr. KONNER. Could I make a point? One of the things you see in the hospitals is nurses with little stickers all over their uniforms. Those stickers are turning them into accountants, basically. They have to keep records of every IV bag they open, of every injection they give. They have to not just deliver the care, not keep the records just for the sake of quality of care, which they have always done, but they also have to answer for every penny that they spend, and I submit to you that that is a waste of a nurse's time and we need to have a system that makes that unnecessary.

Senator WELLSTONE. Dr. Konner, I am going to hand this over to the chairman, but could I just ask, you brought some recent publications with you. Do you want those included as part of the record?

Dr. KONNER. If that is possible, sure. Why not? Thank you.

Senator WELLSTONE. I would like to do that, Mr. Chairman.

Senator METZENBAUM. They will be retained in the files of the subcommittee.

[The booklet entitled "Dear America" by Melvin Konner, MD is retained in the files of the subcommittee due to the high cost of printing.]

Senator METZENBAUM. Dr. Sidel, I wanted to just come back to your testimony because you talked about the fact that the doctors are losing patients, the patients aren't getting free choice, and Blue Cross is really becoming a wheeling and dealing business. Am I understanding you correctly on that, and is there not considerable resentment both among the patients as well as the medical profession by reason of this fact?

Dr. SIDEL. I am not sure exactly, Senator, if I heard you correctly.

Senator METZENBAUM. I am sorry. I meant the question for Dr. Indihar. I apologize. It was he who testified to that fact.

Dr. INDIHAR. There is resentment, indeed, and indeed there is a problem. When we see these kinds of relationships being broken apart, our resentment toward the insurance companies grows. The resentment of the patient toward the insurance companies grows, as well as to their employer, who is also providing these plans and sticking with various plans. So you have this kind of chaotic feeling that is going on in our State right now. It is chaos of the spirit, not so much in the delivery of the health care, but there is this frenzy and chaos and not really understanding what is happening

on the patient's side and the physician's side. It is a very unfortunate feeling of turmoil, and that is what we are seeing.

Now, we understand that with transition you are going to have turmoil. We understand that this is going to happen regardless of what program we pick, but the ones that break apart the doctor-patient relationship and break apart the autonomy, that is what creates the most turmoil. It is not the financing so much; it is the doctor-patient relationship that is the necessary thing.

Senator METZENBAUM. Dr. Sidel, you speak, I gather, for an organization called the Physicians for a National Health Program. Are there a substantial number of doctors in that group?

Dr. SIDEL. 5,500 doctors are full, paying members of that group, but we know that many, many thousands of doctors agree with the principles that PNHP is espousing.

Senator METZENBAUM. Is the membership broad-based across the country or mainly concentrated in the New York area where you are from?

Dr. SIDEL. No. It is entirely across the country, with chapters—I think we are now up to 30 cities in which they are chapters of PNHP, and there are physicians in essentially every State of the Union who are members of PNHP. Surveys of doctors, sir, give us a great feeling that doctors are beginning to understand that the micromanagement of their practice comes with the kind of plan that has been put forward in managed competition and that if they want to avoid that kind of micromanagement, if they want to be able to do the best kind of medical care they were trained to give, they need a system that is different and they need a single-payer system.

Senator METZENBAUM. I am going to ask both Dr. Indihar and yourself, Dr. Sidel, whether you believe that most health care providers would be willing to sacrifice some of the money they make under the current system in order to be relieved of the paperwork burden and endless claims review.

Dr. INDIHAR. Absolutely. I think that this is a great cost to the entire system, as well as to us as individual practitioners. I suspect, however, that as we look at the entire process, I am not hearing much as a delegate to the Minnesota Medical Association and in talking to physicians that reimbursement is a real issue anymore. I think the issue is the doctor-patient relationship. This is what I am hearing. I am hearing about this breaking apart of care.

I think we recognize that reimbursement is going to change, and that is not what people are talking about in the doctors' lounges. That is not what they are talking about at the medical association meetings. They are talking about this loss of autonomy and loss of doctor-patient relationship. That is really the important thing that I am hearing.

Dr. SIDEL. The Metropolitan Life Insurance Company, Senator, in 1991 did a survey of physicians in the United States. They asked those physicians whether they would be willing to accept 10 percent less income if it guaranteed them, number one, less paperwork; two, less utilization review; three, greater malpractice limitations. 89 percent of the doctors responding said that they would accept 10 percent less income for less paperwork, 81 percent said they would accept for less utilization review, and 88 percent said

they would accept 10 percent less income for malpractice limits. Now, that is a single survey and a single amount chosen.

Senator METZENBAUM. Would you give me those numbers again?

Dr. SIDEL. Yes. The numbers are, for less paperwork, 89 percent said yes; for less utilization review, 81 percent said yes; for malpractice limits, 88 percent said yes, at a level of 10 percent less income. Now, a lot more work needs to be done to explain to doctors what the differences are between a single-payer system and what is being proposed in the administration plan. When that begins to be clear to doctors, you will see, as you are beginning to see among the public, a sea change, as I said before, toward single-payer.

Senator METZENBAUM. Dr. Konner, do you believe that American medicine is becoming corporate medicine and that the big insurance companies that are managed care entities are controlling how much or how little medicine doctors provide?

Dr. KONNER. I don't think there is any doubt about that, and that is a trend that has been ongoing for at least 30 years. In around 1980, Dr. Arnold Relman, who was then editor-in-chief of the New England Journal of Medicine, named it the medical industrial complex, but that was sort of mid-stream. Now, there have been increases by leaps and bounds in corporate control over American medicine that has come in various ways; first, the growth of insurance companies; second, the growth of hospital corporations which own hundreds of hospitals; and, third, the growth of corporate managed care.

Now, what has happened in the last few years is that these entities have begun to merge, these different corporate entities, and the line between insurance and managed care is now very blurred and will continue to blur as there is increasing vertical integration in the health care sector. The Clinton plan will, I think, accelerate greatly this whole set of trends, and the concern is that the corporate entities have their primary responsibility to their stockholders. That is as it should be in a capitalist economy, but that isn't necessarily the best thing either for patients or for their caregivers.

Senator METZENBAUM. What do the corporate hospital owners do to make their hospitals profitable, while the nonprofits that are owned by various charitable organizations in various communities—St. Vincent's, Mt. Sinai, St. Luke's—have difficulty in making ends meet and oftentimes they need public subvention? Is it that they totally eliminate any free care, any emergency room operations?

Dr. KONNER. Basically, the for-profit hospitals are able to turn away most patients that can't pay. There are laws that restrict what is called patient dumping, but there are an estimated 300,000 violations of those, which are State laws, around the country each year, and that is 300,000 violations of a very serious nature, patients who are in grave danger of some kind.

The quality of care that those patients get even in a place like St. Vincent's is not great, and in studies——

Senator METZENBAUM. Which St. Vincent's?

Dr. KONNER. The one in New York. Even at a place that is caring for those patients and passing on the costs of caring for them to the well-insured patients, those hospitals, they have shown in recent studies, do not have nearly as good outcomes with those cat-

egories of patients as they do with patients who are properly insured.

You know, I was taught in medical school that every patient who comes through the door gets the same treatment, regardless of whether he is the king of Morocco or a derelict who has crawled in off the street. But the fact is that there are big differences in the quality of care, depending on the insurance status, and I fear that some of those differences may continue in the future even with the Clinton reforms because it will still be in the interests of for-profit corporations to restrict the care they deliver to the poor. The poor will certainly not have as good coverage under the Clinton system as the well-to-do, and the danger of continuing inequality in care is very real.

Senator METZENBAUM. Thank you very much.

Dr. SIDEL. May I comment also on that, Senator? The phrase I think you need to remember in response to your question is cherry picking. We usually use the phrase "cherrypicking" to talk about the procedures of insurance companies to try to only insure those people who will cost them less in claims to the company, but hospitals also do cherrypicking. What hospitals do in cherrypicking is to figure out ways to keep patients who will cost them more money out of the doors and to bring people in who will cost them less money, and this is part of the problem as well.

Senator METZENBAUM. My last question is to Senator Wellstone. Senator Wellstone, you have addressed yourself to the fact that under the Clinton plan the single-payer option will not be available to the States, notwithstanding the fact that the administration has represented that it would be available. Would you be good enough to respond to that?

Senator WELLSTONE. Mr. Chairman, when you were out we were talking a little bit about that. Right now, there are, I think, 4 waivers that are required, and one of those, the Medicare waiver, I think, makes some sense, but the others will be very cumbersome. If you have onerous waiver requirements and, in addition, you have restrictions on States——

Senator METZENBAUM. Who gives the waivers?

Senator WELLSTONE. Well, this would be the Federal Government. I mean, what States do not want to have to do is go through all these waivers, and they certainly want to have the ability to do their own financing. So the devil is in the detail, and it is one thing to say that States will be able to move forward, but what we have to have is language which will, in fact, clearly enable States to move forward.

My guess is that that is going to become a major kind of debate in the health care debate in the United States of America, and I think it is one that we absolutely have to win. I think it is a very, very reasonable proposal. I think, again, if we want to think of our country as a kind of grass-roots political culture, if we want to talk about decentralizing public policy, if we want to talk about States as laboratories of reform, then we are going to have to enable States to be able to have the chance to do this.

Many, many people believe that if States really were able to do it, we would love to be judged by the evidence, and we think the evidence will be that you can deal with the skyrocketing costs and

the plummeting of security for people and actually deliver humane, high-quality, dignified health care out in communities where people live, backed up by specialists. But we have to get an iron-clad guarantee, Mr. Chairman, on this language.

By the way, Mr. Chairman, if this helps with the hearing, I don't have any further questions. There are people that have come from afar, from Canada, and I know there are going to be some comparisons made. There have been, if you will let me editorialize for a second, such outrageous attacks—you know, some real just absolute blatant mythology—that I really look forward to hearing some of the people from Canada talk about their system. So I am very pleased with what the panelists have said in terms of the questions that I had.

Senator METZENBAUM. Thank you very much, Senator Wellstone, and I think the administration should know that the single-payer option on a State-by-State basis, in this Senator's opinion, must be unequivocally clear. If the State wants to go to the single-payer option, I don't think there ought to be any question about it. I don't know what all these waivers and all that gobbledy-gook is about, but it seems to me that the price of some votes for that bill may very well be the opportunity for the individual States to go in that direction.

I want to thank the panel very much. We have other panelists who are with us, as Senator Wellstone has already indicated. Thank you very much to each of you.

Senator METZENBAUM. Our next panel is Michael Walker, Ph.D., executive director of the Fraser Institute of Vancouver, British Columbia; Hugh Scully, a cardiology surgeon at Toronto General Hospital; Michael Rachlis, a physician at the Hassle-Free Clinic. That is an interesting name. I don't know if that has to do with a man's name or whether it is Hassle-Free. We also have Theodore B. Marmor, a professor of public policy and management at Yale University.

We are very happy to welcome all of you to this hearing. I think you know of our 5-minute rule. I might say for myself, I chaired a Canadian-American conference last year that was held up in Nova Scotia and the Canadian part was headed by a doctor whom they called Stash. I don't remember his exact name—Barootes.

Stash told a very interesting story to all of us assembled there about how he had led a 22-day strike of all of the doctors in Saskatchewan when the single-payer plan was first put into effect in Canada, but that now he is a gung-ho supporter of it, and all the rest of the doctors are as well. I found that story a very, very interesting one, and we may hear other comments either supportive or disagreeing with that point of view.

But let us start with you, Dr. Walker. We are happy to have you with us today.

STATEMENTS OF MICHAEL WALKER, EXECUTIVE DIRECTOR, THE FRASER INSTITUTE, VANCOUVER, BRITISH COLUMBIA, CANADA; DR. HUGH E. SCULLY, CHAIR, HEALTH POLICY COMMITTEE, CANADIAN MEDICAL ASSOCIATION, TORONTO, ONTARIO, CANADA, ACCOMPANIED BY WILLIAM THOLL, DIRECTOR, HEALTH ECONOMICS AND POLICY COMMITTEE, CANADIAN MEDICAL ASSOCIATION, TORONTO, ONTARIO, CANADA; DR. MICHAEL M. RACHLIS, ASSISTANT PROFESSOR, DEPARTMENT OF CLINICAL EPIDEMIOLOGY AND BIOSTATISTICS, MCMASTER UNIVERSITY, HAMILTON, ONTARIO, CANADA; AND THEODORE R. MARMOR, PROFESSOR OF PUBLIC POLICY AND MANAGEMENT, YALE UNIVERSITY, NEW HAVEN, CT

Mr. WALKER. Well, thank you very much, Senator. I am certainly delighted to have the opportunity to appear before your committee and, in particular, to bring results of some research which the Fraser Institute has done on hospital waiting lists in Canada.

The Fraser Institute is a federally-chartered nonprofit research organization which conducts studies of public policy issues in Canada. The Institute has published three book-length studies which examine Canada's health care system from different points of view. The latest study, "Caring for Profit," was conducted by Professor Malcolm Brown, a self-professed advocate of Canada's single-payer approach to the health care system. Other books which we have published have taken different points of view.

The Institute also conducts an annual survey of physicians to determine the extent to which access to health care is rationed as a result of the fact that the demand for health care is steadily increasing, but the supply is limited by a series of budgetary caps.

The survey produces two measures of rationing—the waiting times for appointments to see a specialist, and the waiting time for treatment once the specialist has been seen. Since all patients in Canada proceeding to either of these steps must first have been to a general practitioner for a referral, it can be reasonably assumed that those waiting represent legitimate unsatisfied demand for care.

While a survey of specialists may be the only practical way to determine specialist waiting times, it is not the preferred way to measure hospital waiting lists. The Institute adopted this survey approach only after ascertaining that hospitals do not have the information required to build a comprehensive waiting list at the moment.

The publication of our surveys for the past several years has stimulated considerable interest in the area, and hopefully in several years' time provincial governments will publish comprehensive hospital-based waiting lists of a kind which are typical, for example, in the United Kingdom.

I have provided you with copies of this year's survey and a press release which was issued in Canada when the survey appeared earlier this year. I apologize that I have not prepared a special brief for your hearing today, but I was informed only on Friday of your desire to have me come and I was in the neighborhood anyway on my way to Ottawa, so I was able to appear, but not having the time to actually make a presentation because many of our studies

are at the moment hotly contested in the current Federal election campaign in Canada and our attentions must be devoted to those issues.

Now, there are, nevertheless, many interesting aspects of the studies that I have given you, but two seem to be of particular relevance to your deliberations. The first is the fact that it is a misnomer to refer to the Canadian health care system as though it were one uniform system providing similar service for all Canadians. In fact, access to the health care system varies dramatically depending on where in the country one encounters it.

You have been given a copy of this press release, I think. Do you have it with you there so that you can look at the chart because I think it is very instructive to look at the chart on page 2? It is chart 1 in the release, where you can see the average total waiting time from referral by the general practitioner to treatment.

[The press release will appear at the end of the hearing record.]

Mr. WALKER. As you can see, that waiting time varies amongst the provinces from 11 weeks in Ontario to 21 weeks in Prince Edward Island. Wait times also vary within provinces amongst specialties. In Ontario, for example, where the overall waiting time was the shortest, the waiting times vary from 3.7 weeks for urology to 12.6 weeks for ophthalmology. The fact that Ontario has generally the shortest waiting list may be of particular interest to the committee, owing to the fact that Ontario was the only province studied when your General Accounting Office did a mini-study of waiting lists a few years ago. Evidently, Ontario is not typical, as the survey shows.

Senator METZENBAUM. Would you be good enough to explain—when you say waiting time for an appointment, does that mean that if I don't feel well and I want to call a doctor and I want an appointment that I have to wait the number of weeks stated here, or are these for special kinds of specialists?

Mr. WALKER. Well, what it means, Senator, is if you go to your general practitioner, typically the waits for general practitioners in Canada are nonexistent. You will not have to wait to get to see a physician. However, once you go to a physician and the physician discovers that there is something wrong with you and suggests that you should go to a specialist for whatever specialty happens to be a problem, you then face an average of about 5 weeks waiting for specialties across the provinces.

Then, having waited for that 5 weeks, what the survey shows is you then have to wait an additional amount of time for the treatment which the specialist may then prescribe, for a total waiting time in Ontario of about 11 weeks, on average, and a total waiting time, on average, in the longest province of 21 weeks.

Senator METZENBAUM. What if it is an emergency? What if you need the treatment immediately and you can't wait 5 weeks?

Mr. WALKER. Well, if you presented to an emergency ward at a hospital, for example, then you would be treated in the same way as you are here. You would be treated on an emergency basis and dealt with. In fact, physicians in Canada are—if they have patients who they are concerned will have to wait, they are not above suggesting to them that they should do exactly that, present to a hos-

pital waiting room as an emergency and they will then be seen on an emergency basis.

Senator METZENBAUM. Now, what if you go to the doctor and doctor says, you have some congestive heart failure, you have some problems that probably need surgery. Perhaps it is a broken leg and you need surgery, or any one of a number of other things; your kidneys are not functioning. For all of those, you have to wait 5 weeks, 10 weeks?

Mr. WALKER. No. You consider, for example, the case of cardiac surgery. There are generally three different classifications—emergent, urgent, and elective. Now, the emergent would be if you don't have the operation right now and you would die, you would get done right away. If it is urgent, then your life is in threat, but not in immediate threat.

Recently, as undoubtedly Dr. Scully will be able to tell you, the heart physicians in Canada have come up with a classification system to know when somebody is either emergent, urgent, or can be put on the elective list. Now, the elective list means that your life is not immediately threatened, and you may then wait for a very long time in some provinces. But generally for emergent care, you don't wait. Well, when I say you don't wait, the average waiting time, I think, for emergent cardiac surgery is something like 3½ days.

Senator METZENBAUM. So these charts refer more to elective procedures?

Mr. WALKER. No, no. They include all of the various procedures. They are weighted. In other words, we survey all waiting times, not just for elective surgery. In the case of cardiac care, we make special divisions of those who are regarded as emergent, urgent, and elective.

Senator METZENBAUM. What if your leg is broken? Would you get taken care of immediately?

Mr. WALKER. If your leg is broken, it would be taken care of immediately, sure. You would not wait, but if you are, without being in any way invidious, Senator, a person of elder years who has a hip which requires replacement, then you would undoubtedly wait in every province in the country, and you would wait in some cases for more than 3 months, in some provinces, in fact, more than a year, to have a hip replacement which may be causing you considerable pain.

Senator METZENBAUM. What if you needed kidney dialysis?

Mr. WALKER. Well, the survey at this point does not cover all of the attendant treatments that people require, and we don't have a special separate measurement of the situation with regard to kidney dialysis. However, since we do give physicians the opportunity to write in about issues that are of concern, nobody has raised it as an issue. So I presume that in the case of kidney dialysis that at the moment it is not a particular problem.

Senator METZENBAUM. I cut you off, so take a couple minutes more if you need it.

Mr. WALKER. Thank you very much. Well, the second interesting aspect of the survey, and that relates to the first, is the apparent correlation between the waiting time for treatment and the amount of money which the various provinces spend on health care.

May I ask you now to look at the chart on page 4 of the handout you have? That provides you with the ten provinces' average waiting times and the amount that is spent per capita on health care in the different provinces. As you can see, there are two groupings of waiting times and these are roughly aligned with the amount the provinces spend per capita on health care.

Those provinces which spend more per capita on health care, on average, have shorter waiting times than those which spend less, and the break point seems to be just less than $1,500 per capita. Those who spend more have reduced waiting times by comparison with the provinces that spend less than $1,500 per capita.

I might point out, by the way, Senators, that these figures are just the amounts that governments spend and do not include the amount that private individuals pay to support their own health care in the provinces. It is not strictly comparable, in other words, to the aggregate amount per capita that is spent in the United States.

In particular, Ontario, which spent the most per capita on health care, has the shortest waiting time, while Prince Edward Island, which spent the least, has the longest. Now, evidently, this point is of some significance when Americans look to Canada for guidance in revising their health care arrangements. What the Canadian experience seems to suggest is that centralized control of health care spending can indeed limit the total amount which is spent.

However, with rising levels of demand, the inevitable consequence is rationing of care, and the tighter the spending control, the more rationing will result and the longer will people have to wait for care. In other words, as Americans look north to Canada, they have to decide whether they want a health care system like Ontario, with its 11-week waits, or like Prince Edward Island, with the 21-week wait. If they don't like the idea of 11-weeks waits, then they should avoid budget-capping as an approach to health care, whether that comes about as a result of the current plan proposed by Mr. Clinton or by some alternative such as a single-payer system.

Now, one of the panelists in the first session noted that the Canadian system is not the British system, and said that you didn't have to think of the problems of the British health care system as you looked at potentially modeling yourselves on Canada. Of course, while that has been true, the question is whether budget caps aren't driving the Canadian health care system in the British direction.

In this connection, I was led to begin studying waiting lists in Canada by the discovery during a visit to London in the early 1980's of a small book published by the Greater London Area Authority, a regional government body.

Senator METZENBAUM. Will you try to wind up, please, Mr. Walker?

Mr. WALKER. Yes. I am finishing one sentence, Senator. The booklet was entitled "A Guide to Greater London Area Hospital Waiting Lists." Presently, 2 percent of the British population are waiting for health care, an outcome which the Fraser Institute wishes to avoid for Canada by publishing these waiting lists now

before they get very extensive, and presumably which you would like to avoid for the United States.

Senator METZENBAUM. Thank you very much, Mr. Walker. Your testimony was very helpful.

Dr. Hugh Scully, we would be glad to hear from you, sir.

Dr. SCULLY. Thank you, Senator, and I appreciate very much the opportunity of coming and speaking with you today as the United States, as other countries, are engaging in the examination of priorities and spending and what is happening with health care.

I come to you today as a representative of the Canadian Medical Association, the chairman of the group that is looking at the financing of health care, not in the context of a cardiac surgeon and a professor of surgery, but we can get into that later in questions, if you like, and in that context represent the views of the 65,000 doctors of Canada who are practicing in the system and who have been examining it and participating in it for some time.

Any examination of the health care system in the United States, with the majority of Canadians living within 100 miles of the border, has tremendous implications in terms of what is happening with us. One of the things I was asked to address is some of the myths that exist about the Canadian health care system, and I can tell you that as a practitioner and as a leader in medicine in Canada, if the myths are inaccurate and are published widely in the American literature and press because of our proximity, then we find ourselves in the awkward position of trying to make the system work better while at the same time responding to what are often inaccurate statements about the system.

So I will briefly—and there is a list of speaking notes that you have and much more detail in the report of my working group on health financing which is available to you.

Senator METZENBAUM. All of the statements of each of the witnesses will be totally included in the record.

Dr. SCULLY. I will touch on just a few of the situations. The first myth is that Canada has a system of socialized medicine, and that has been promulgated widely from time to time. That is particularly irksome to physicians and simply is not the case. What Canada does have is a socialized insurance scheme with standards that are established nationally and applications and administration carried out at the provincial or territorial level, which is the equivalent of the State level.

The predominant funding is a single-payer system, with the government being the agent on behalf of the people. I say "predominant" in the sense that there is some private participation, also, and we could get into that later. The way that works for physicians is that physicians really are quite independent of government control, have more autonomy and decisionmaking ability generally speaking than is the case in the United States.

Similarly, the 1,200 hospitals of Canada are in a situation where they have boards of trustees who are accountable to the public through public representation and to the government and to the staff in a nonprofit situation. The hospitals are not there to generate a profit, but rather to look after the care of the people as they present themselves.

The second myth is that Canadians are dying on waiting lists, and you heard some discussion of waiting lists. I will simply say that at the professional, academic and administrative level, there is strong disagreement with some of what was presented to you a few minutes ago. I think it would be inappropriate for me as a guest in your home to get into a debate about my own.

Moreover, in terms of the legislation that you have and the plans that are here, as a guest in your home I am not about to tell you how to rearrange your furniture, but simply to comment on the Canadian system because there are many good things about the American system that we learned from.

In terms of the waiting times, no country is free of some interference with access for one reason or another. What we work very hard to do, however, in Canada is to work together with the governments and with the other health professionals—the nurses and the hospitals and the public—in addressing what is needed. I can report to you that 97 percent of Canadians feel that they get the care that they need within 24 hours every time, so there is a system that certainly satisfies the public of Canada.

Furthermore, the majority of physicians, 83 percent in a survey last year, feel that the system works well or in an excellent way for the majority of the patients. That isn't to say that it is perfect, but on balance it works very well for most of the people who require care.

The third myth is that there is a deteriorating quality of care, that somehow or other the process of health care in Canada is sinking or has sunk. Again, I take issue with that. Canadians rate the quality of their care as excellent or very good. I have already related to you how physicians feel about that, and indeed as one looks at Canada as a rating internationally, one of the issues that rates it highly as a place to live internationally is the quality of health care that is available to patients, wherever they may be from, whatever their financial status, across the country.

The fourth myth is that Canadian health care costs are out of control and that the system is about to go bankrupt. There are problems, that is true. On the other hand, we are not spending as much as a percentage of GDP as is true in the United States, and what we have looked at in terms of the economy is how we can work together not to spend more money, because spending more is not the equivalent of getting better care or better access, but how we can spend it better. In that context, physicians and others are working in partnership to try and examine what we can do to provide necessary care to all Canadians when they need it, whether it is an emergency or an urgency or an elective situation.

Senator METZENBAUM. At that point, would you sort of comment on the income of members of the medical profession in Canada as compared to the income of members of the medical profession in the States?

Dr. SCULLY. In general, overall, about 15 percent of the health bill in Canada goes to pay physicians. In the United States, depending on who is doing the counting, that is 19 to 21 percent. In many disciplines, the average income is about the same between physicians in the United States and Canada. Canada's tax system

taxes those who do well somewhat more than is true in the United States, so there is less disposal income at the end of the day.

The other thing that has resulted from the negotiation of fee schedules or benefit schedules in Canada, which at the present situation in the States would violate antitrust law, is that there is less of a spread within the profession between the top and the bottom. There is less disparity; there is some, but there is less disparity between the primary care physician and someone like myself as a practicing cardiac surgeon. So while I do better than the primary care physician, I don't compare to my counterpart in New York in terms of income.

The fifth myth, and I really just have a few others, is that health care consumers and providers are flocking to the United States. With regard to Canadian patients coming to the United States, the out-of-country payments have been at 2.5 percent for some time, and indeed are going down as Canadian governments are insuring less for those who travel outside of the country.

America has some of the best medical centers in the world and that is admired and respected by everybody, and I pursued some of my own training at Harvard, recognizing that situation. So it is the case, as from all over the world, that for some of the centers there will be international patients. That should be and always will be the case.

So far as physicians are concerned, the net migration of Canadian physicians to the United States has stayed stable at about 200 in terms of net transfer back and forth over the course of the last few years. There are 65,000 doctors in the country. It isn't a mass migration to the United States, although I must say parenthetically that if primary care becomes the access to specialists and other care in this country and only 9 percent of the physicians being produced in the medical schools in the United States are presently in primary care, we are concerned that we may lose all of our primary care physicians to the United States.

The sixth myth is that we ration care in favor of the rich and powerful, and some reference is made to that, and that simply is not the case. There is in any country the power of affluence and the power of influence. That is a fact of life and a reality that everybody lives with.

What Canada has been able to do with a universal system is to close the gap between what is accessible and available to people of any income group, ethnic group, or geographic distribution, and that has been very successful and really has been recognized internationally as one of the pluses of the system.

Finally, the myth that is true universally, we think, as physicians is that doctors are largely to blame for the rising health care costs. The whole issue of what doctors do is being examined in every country. There is no question about that and that is very important. What we are doing in Canada to examine that, quite apart from the utilization and the practices that we have, is working in partnership with government, with hospitals, with nurses, with community groups in examining what we are doing in order to be able to do it better, to be able to do it for less, to bring it closer to what the patient is, which, after all, is the reason why we are there, without at the present time, and hopefully in the future, a

lot of interference from the point of view of second-guessing and second opinions and administrative interference.

Now, those are some of the issues, Senator, that have been particularly irksome, I think, to Canadians. Our reality overall is that our country, as is yours, is examining the health costs, what constitutes the health costs, and what we can do. Our reality, I think, is the same as yours that we cannot continue to spend evermore on health and compromise dollars that could be usefully used otherwise to benefit society generally, and we are certainly active and enthusiastic partners in that system.

[The prepared statement of Dr. Scully follows:]

PREPARED STATEMENT OF DR. HUGH E. SCULLY

Ladies and gentlemen, i is indeed a pleasure for me to be here this afternoon on behalf of the Canadian Medical Association. Let me say from the outset that, in agreeing to appear before this subcommittee, our aim is not to try and persuade the American people to adopt our system or any other single payor system. Rather, our aim is to close the gap on some of the misinformation that continues to abound in reports coming out of the United States about one such system—the Canadian system. The just-released report from the National Center for Policy Analysis is a case in point.

The question might then legitimately be asked: Why would Canadians worry about the misinformation being circulated in the U.S. about our system? Why bother to make the effort to set the record straight?

The answer is partly national pride and partly self-defense. Not a day goes by that Canadians are not subjected to a wide array of purported failings in their system from U.S.-based media. The average American may not know that over 80 percent of Canadians live within 100 miles of our shared border. Virtually every Canadian can now tune in via satellite or cable to any number of U.S.-based television programs or read any number of major U.S. newspapers. When average Canadian physicians hear or read distorted reports about their health system they expect leaders in the health community to challenge such reports. More specifically, to allow misinformation about the ills of Canada's health system to spread widely in the U.S. makes our task back home of making a good system better just that much more difficult.

So the CMA is not here today to advocate our system, just explain how it really works. Nor are we here, as one columnist recently wrote in the Canadian Saturday Night Magazine as "naive and chauvinistic boosters"[1] of Canadian government policies. The perspective I am about to share with you is one shared by most practicing physicians across Canada—the same physicians who helped build the system and now help make it work to serve all Canadians' health needs.

Given the short advance notice of this hearing, my remarks will of necessity be brief and will fall into two broad categories: stylized myths and emerging realities.

STYLIZED MYTHS

It is difficult to know where to begin or end in terms of tackling the many myths without targeting some of the specific sources. (Unfortunately, some of the myths have their origins in Canada.) I have elected to focus on those statements that tend to be most frequently reported and are most off the mark.

Myth One: "Canada has a system of socialized medicine."

Statements such as these are especially irksome to Canadian physicians. The majority of Canadian physicians are paid on a fee-for-service basis and are able to practice as independent entrepreneurs. Many are incorporated as small businesses. Physicians bill provincial plans for insured services approximately every two weeks and almost always receive prompt and complete payment. While we have been denied the option of balance billing patients since 1984, the medical profession (through the CMA's divisions) has an opportunity every few years to sit down with governments and negotiate payment arrangements.

Similarly, virtually all of Canada's 1,200 hospitals are accountable, not to government, but to local community Boards of Trustees. Here, too, budgets are set prospectively as a result of annual negotiations.

[1] Malcolm Gladwell, Saturday Night, October, 1993.

Thus, Canada has a (primarily) tax-financed hospital and medical system—it is a system of social insurance not socialized medicare.

Myth Two: "Canadians are dying on Waiting Lists."

One can always find unfortunate instances of where the system has fallen short of an individual's health care needs. Certainly there is always room for improvement and we must always try to learn from our mistakes. But no country in the world is free of the human realities of unnecessary premature morbidity and mortality. One of the more outrageous claims about our system, however, comes in the form of the October, 1993 report of the National Centre for Policy Analysis (NCPA). In this report, data are drawn from a Canadian study by the Fraser Institute that has been roundly criticized by the academic community and by the community of physicians from whom the information was derived. (Copies of detailed critiques have been provided to the Sub-Committee). The NCPA report also cites a 1991 Statistics Canada survey that found that an estimated 1.4 million Canadians reported some delay in receiving care and that of these "more than 177,000 people are waiting surgical procedures."

To put these figures in perspective, it should be noted that it is difficult to judge urgency as there is no objective standard for defining the level of urgency. In this survey 6.6 percent of the adult population reported experiencing a delay in obtaining health care. It should be emphasized, however, that among those experiencing a delay, fewer than one out of five reported a delay in obtaining hospital emergency treatment (247,000—17 percent) and just one in ten reported a delay in hospital admission for surgery (155,000—11 percent). Moreover among those reporting a delay in hospital emergency treatment almost one out of two (47 percent) received treatment within 3 hours, and just one out of six had to wait more than 24 hours. The truly emergent and urgent (life threatening) do receive immediate care. You simply cannot conclude from these data that a significant proportion of Canadians have to wait for urgently-required medical treatment.

Myth Three: "Deteriorating Quality of Care."

Various reports in the U.S. have suggested that Canadians are not getting good quality care. Such reports seldom mention the fact that Canadians score significantly higher than the U.S. (and most other industrialized countries) on every international standard of health outcome measure. Such reports also tend not to mention the polling results in Canada about this question. Lest there be any doubt about what Canadian consumers and providers think, let me share with you just a few recent results. According to an April, 1991 poll: 84 percent of Canadians rate the quality of their medical care as excellent or very good and 86 percent rated their health system as excellent, very good or good. Similarly, a recent survey of Canadian physicians (Spring, 1992) found that 83 percent of physicians believe that they are able to provide good or excellent care, free of bureaucratic or government interference.

Myth Four: "Canadian Health Care Costs are Out of Control."

Despite repeated rebuttals in peer-reviewed journals over several years now, some commentators continue to play with the figures until they get the desired result. Next to the U.S., Canada spends more on a per capita basis than any other country in the world. Annual cost increases have been brought under control, however, over the past number of years. Also true, in 1991, the most recent year for which data are available, the annual increase in real health care spending was just 1.1 percent. In terms of the publicly-financed share of total health spending or about (72%), real per capita spending has been frozen and, it is now widely believed, is in decline. The reason is that Canada is still suffering the economic shocks of four recessions in less than a decade and continues to spend about 30 percent less in per capita terms than the United States. In 1991, the most recent year for which data are available, health spending in Canada as a proportion of Gross National Product stood at 9.9 percent as compared to over 13 percent in the U.S. and by some estimates the gap appears to be growing.

Myth Five: "Health care consumers and providers are flocking to the U.S."

Again, the data simply do not support such claims. Estimates prepared by Carol Clemenhagan, President of the Canadian Hospital Association show that the proportion of Ontario Health Insurance payments made out of Canada has remained constant since 1982 at about 2.5 percent of total payments. Most of these "out-of-country claims" were for Canadians falling ill while travelling or visiting.

Nor are Canadian physicians rushing to buy one-way tickets to U.S. destinations in great numbers. While there was an increase in 1992 (689) Government of Canada figures show that since the late 1980s about 400–500 physicians leave Canada each year, and about three hundred come back.

Myth Six: "Canada Rations Care in Favour of the Rich and Powerful."

Every country in the world must ration finite health resources among competing needs—this is what health economics is all about. The choice is not whether but how to ration. Over thirty years ago Canadians elected to allocate their considerable health resources according to relative medical necessity. So did most other developed countries of the world. (The alternative was to ration according to ability to pay.)

Numerous Canadian studies clearly show that the gap in per capita use across socioeconomic groups was significantly reduced with the advent of universal hospital and medical insurance programs. The fact that significant health inequalities still exist in Canada—and every other country in the Western World—simply reflects the variety of other, more fundamental determinants of health status. To point to such inequalities as an indication that Canada favours the rich and powerful lends a whole new meaning to the old adage that necessity is the mother of invention"! The NCPA has stooped to new lows in suggesting that global budgets in Canada have been targeted at or discriminate against Canada's poor, elderly, or social minorities. The data simply do not bear this out.

Myth Seven: "Doctor's are largely to blame for rising health costs"

The claim that doctors are largely to blame for rising health costs is not unique to Canada. One of Canada's noted health economists for example has stated that "fee-for-service is the root of all evil". Bureaucrats and politicians uncritically repeat estimates that from 20–30 percent of what doctors do is unnecessary, and it is often asserted that doctors are obstacles to change. With regard to physician remuneration the best conclusion that can be drawn from the available evidence is that there is no one best method of paying physicians. Indeed at the present time only two-thirds of physicians in Canada obtain 90 percent or more of their professional income from fee-for-service; a wide variety of alternative modes are available. With regard to inappropriate medical care, a major problem to date has been the lack of sufficient information and data. In Canada we are moving quickly to address this through research on health outcomes and clinical practice guidelines.

The medical profession is working very actively in this area in many instances cooperatively with government. The Institute for Clinical Evaluative Sciences in Toronto was established through the Joint Management Committee of the Ontario Medical Association and the Ontario Government. There are similar joint efforts underway in virtually all jurisdictions in Canada. I would add that the CMA has undertaken a major quality project; part of which has been the formation of a national partnership on clinical practice guidelines. Suffice it to say that doctors want to be and should be part of the solution.

These, then, are just seven of the more oft-repeated and misleading statements sometimes made about the Canadian system. But if these are the myths surrounding the problems we face, what are the realities?

REALITIES

Canada certainly has its fair share of health challenges when it comes to doing more with the same or even less. But we are not alone in facing many of these challenges. Virtually every country in the industrialized world is looking to reform its health care system or has already done so. The same is true of Canada—we are in the process of reforming the system.

Again because of the constraints of time, we can only provide you with an overview of some of the key challenges. A Working Group, which I chair for the CMA, recently released a discussion paper entitled "Toward a New Consensus on Health Financing in Canada." Copies of this paper have, I believe, been made available to committee members and I invite you to refer to the details contained in the paper covering the points I am about to make.

Canada's system of organizing, financing and delivering health care services has always tried to balance the objectives of affordability, on the one hand, with accessibility to good quality care, on the other hand. The recent world-wide economic down turn and the conservative economic outlook have fundamentally disrupted this long-standing balance.

The CMA discussion paper sets out a number of pressures on the system—demographic technological and attitudinal, and identifies options for the future. But the critical problem is what we refer to as the "affordability crisis" in Canadian health care. On a per capita basis, Canada is now one of the most indebted nations in the world. While the numbers in absolute dollar terms may not have the same reaction here as at home, they are grim. With unemployment standing at 11 percent and forecast to continue at this level for sometime and with an accumulated public debt of some $650 billion—87 percent of our annual Gross National Product—governments are being forced to make hard choices. With over $67 billion going to health

care in total each year and, on average, one-third of provincial government spending going to health care each year, global health budgets are being frozen or, in some cases, even rolled back.

As governments have been forced by rising debt-servicing costs to reevaluate spending priorities, better health planning and management have not always or even usually been the focus. The federal government has, in some cases, simply tried to pass part of its debt management problem on to the provinces in the form of reduced fiscal transfers for health problems; in what Ted Marmor has referred to as a "policy by stealth." Meanwhile, some provincial governments—especially in the poorer regions of the country—have been forced to cut costs in any number of ways: capping hospital budgets resulting in bed and/or hospital closures, reducing out-of country health benefits, de-insuring certain non-essential medical services, reducing/eliminating child dental benefits and reducing drug benefits to seniors (or increasing co-payments) and capping physician incomes.

The effect of many of these often uncoordinated measures has been to shift an ever increasing share of the total health bill on to the private sector. It may surprise some of you to learn that the public sector now accounts for about 72 percent of total spending in Canada; down from a high of 78 percent just a few years ago. This process of passive privatization has now put Canada well below the average for industrialized (OECD) countries. It is also not that far ahead of the U.S., if one factors in what economists refer to as the "tax expenditures" built into your system of health financing.

As the Working Group's discussion paper suggests, Canada may now have reached the point where we must reconsider whether we can continue to fund "everything for everyone". Since there is still very strong support for the principal of universality, the debate in Canada has now centered on the question of more carefully defining or proscribing what are core medically-required services. Increased attention is also being focussed on what can be done from a public policy perspective to define a more effective partnership between public and private (supplementary) health plans. On both counts, Canadian policy makers at the government, institutional and clinical levels will be looking with more than passing interest at the debate unfolding in the United States. This issue of defining "core benefits" is clearly central to the debate here in Washington around health reform. So too is the question of the interface between public and private insurance markets.

To summarize quickly, our objective this afternoon has been to give you an honest assessment of the myths and realities of the Canadian health system to "close the gap" on misinformation. The challenges we face may differ in degree but appear to be converging in terms of direction. The need for change is not disputed. The challenge is to recognize it, embrace it and manage it on both sides of the border and let us not have misinformation stand in the way. Thank you for your attention.

Senator METZENBAUM. Thank you very much for a very reasoned and balanced approach. It is certainly very helpful to us. How many years ago did the Canadian system go into effect?

Dr. SCULLY. The debate began really coming out of World War II, the depression and World War II and in the 1950's, and it was in the province of Saskatchewan and moved west and then moved east, and it resulted, in 1962, in legislation in Saskatchewan to do with health services and professional services. In 1957, there was a hospital insurance act passed nationally, which I might point out was supported unanimously by all of the political parties across the country.

In the 1960's, physician services were included in terms of publicly financed insurance for all patients, regardless of barriers. Finally, in 1984 the Canada health act enshrined the 5 principles upon which the Canadian health care system is based.

Senator METZENBAUM. What do you do about malpractice up there?

Dr. SCULLY. The malpractice situation is not as severe as it has been in the United States. I would point out, however, that there has been a significant increase in recent years, and again there is a spillover effect, the coat-tail effect, that we sustain as a consequence of being good neighbors to the north. As a percentage of

earned income, which I think is what it comes down to, many physicians in Canada are paying as much as their counterparts in the United States as a percentage of their earned income. The absolute numbers are quite different. There is an urgent need in our country also to address the issue of malpractice, defensive medicine, and the costs that are there.

Senator METZENBAUM. Thank you very much.

Dr. Rachlis, a physician from the Hassle-Free Clinic.

Dr. RACHLIS. Good afternoon, Senator. My name is Michael Rachlis. I am a community medicine physician. I am a part-time professor at the department of clinical epidemiology at McMaster University in Hamilton, Ontario, and I also work part-time at the Hassle-Free Clinic in downtown Toronto. But, primarily, I earn my living as a private consultant in health policy and as an author on health care issues.

Senator METZENBAUM. Is the Hassle-Free Clinic named after somebody or does it mean there aren't any hassles there?

Dr. RACHLIS. Well, it is interesting. It is the latter, mainly, and it was developed in the 1960's before we had public medical insurance in Canada, in Toronto, and when we had many kids on the street who needed health care. So it was set up by dedicated physicians, nurses, and others to provide free medical care to people who needed it.

Then, of course, as public medical insurance was implemented, we didn't need to provide general medical care and the clinic focused subsequently on sexually-transmitted diseases, AIDS, and family planning.

Senator METZENBAUM. So hassle-free actually means it is free of hassles?

Dr. RACHLIS. That is what it meant.

Senator METZENBAUM. Thank you.

Dr. RACHLIS. I would like to start off by briefly drawing an analogy with something that is a favored activity in both of our countries. 150 years ago, there was a game that resembled baseball that was played near London, Ontario. One year later, Abner Doubleday wrote down the rules of the game and modified the game that had been first played in Canada.

Fast-forward to 1977 and the Toronto Blue Jays come into the American League and, of course, 15 years later, after we have learned so much from you people about baseball, we won the World Series. Of course, God willing and a good wind, we will win this year again. [Laughter.]

Dr. RACHLIS. So I hope that such productive exchange which has produced the game of baseball will produce better health care in both our countries, and in that spirit I would like to give something to the committee, if I could, from Canada. I have a Toronto Blue Jays hat that I would like to give to the chairperson, although I would not be aggrieved if you didn't wear it back home, but I have worn one in Cleveland's fine stadium myself.

I also have some Blue Jay baseball bats which you may find useful in beating off some of the special interests that I hear are trying to influence you on these matters. I have enough for every member of the committee. [Laughter.]

If I may go into my formal remarks, I find myself on this panel in quite a bit of agreement with what Dr. Scully has had to say that there are a lot of stories about the Canadian health care system which are frankly offensive to Canadians. They are usually produced by American special interest groups that are, of course, trying to influence your policy debate, but occasionally by Canadians themselves.

I am offended by them for two reasons. First of all, many of them are just frankly untrue, and I have documented such a case in my written testimony about a Mr. Albert Mueller who was claimed to be on a very long waiting list for heart bypass surgery in Vancouver, when it turned out that a further investigation by myself of the particulars of the situation indicated that he could have had his surgery almost immediately for his very serious heart problem, but he had chosen himself on many, many occasions to postpone the operation. He never did want to have the surgery. He finally did have it a couple of years after the initial diagnosis.

But there are many such myths about patients in the Canadian health care system and, in fact, I see a couple of them in the document that was recently produced by the National Center for Policy Analysis jointly with The Fraser Institute. I would advise Americans that when you hear something about the Canadian health care system which doesn't seem to be true, don't immediately believe it because quite often the stories will be found to either be frankly untrue or not as written.

However, the Canadian health care system does have, certainly, many problems, and one of the major problems that the health care system in Canada has is a lack of management. As Dr. Scully has indicated, we don't have socialized medicine in Canada. We have what another Canadian physician and author has referred to as public payment for private practice, so that we don't have a government-run system.

Quite frankly, we don't find that sometimes the private management is really managing the resources very well either, and I think that the example of cardiac care is a good one where in the late 1980's there were a number of press stories about problems in Toronto with access to heart surgery. Some of them were not true, or certainly not true as written, but there were problems that had developed in the late 1980's for a variety of reasons and a committee of cardiac surgeons and cardiologists and epidemiologists, with some government facilitation, developed a prioritization system in Ontario which has led to a dramatic decrement in waiting times there without the infusion of very many new resources, about a 10-, 15-percent increase in overall patient volume.

I think that one of the major lessons of that episode is that many times the true problems that we do have in our system are not due to lack of resources, forced rationing from global budgets, etc, but rather due to lack of management because government, if anything, is, in my view, a little too hands-off in Canada, trying to abide by the social contract that they feel they signed with public health insurance, which was that they would supply the money and then the medical profession, administrators, and others would run the system.

A second problem in Canada that I think bears on your debate is that many problems that we do have reflect Canada's implementation of its single-payer system. Single-payer simply means that you have a single source of finance, which I believe is about the only way in which a society can guarantee access and have major macro levers for controlling costs.

But there are many different systems of delivery of care that can be developed within that. Just as an example, one of the problems we have in Canada is that we do have a proliferation of what are referred to as walk-in clinics, with over 100 in the metro Toronto area mainly staffed by general practitioners who don't have regular family practices. Patients are quite frankly encouraged to come in and see a physician for very, very minor problems.

At the other end, I think that we do have some lack of access, or we could have better access for certain types of procedures like hip replacements, for example. But that doesn't mean that you have to implement a single-payer exactly the same way as we have, and just as implementation of single-payer in the United States is no guarantee that you will win the World Series, it also is no guarantee that you will get our set of problems. You will probably get some other problems as you implement it in your fashion that you are going to have to deal with.

So I think with that I would like to close my official testimony and, if I can, present you with your mementos from Canada.

Senator METZENBAUM. Fine, thank you.

[The prepared statement of Dr. Rachlis appears at the end of the hearing record.]

Senator METZENBAUM. Dr. Marmor, I have to apologize to you, but I have a meeting with the Leader on a totally different subject and please forgive me for having to leave. We will take a look at the record, but Senator Wellstone will carry on.

I want to thank all of you from Canada. You have been particularly helpful. I think your testimony has been extremely lucid and very informative, and it has meant a lot to us and we will try to share your comments with our colleagues because I think there is considerable misinformation about the Canadian system. I congratulate you on it and hope that we can move in a somewhat similar direction. Thanks a lot.

Senator Wellstone [presiding.] Thank you, Mr. Chairman.

Mr. Marmor.

Mr. CMARMOR. Thank you, Mr. Chairman. I understand the problem. I should have known, with Michael Rachlis to my right, that there would be some special hijinks that would cover the activity. I have no gifts to give you at all, but I do have 25 years of experience writing about medical care, politics, and economics, and what I would like to do, Senator Wellstone, is in the short time that we have allowed for presentation, instead of going over all the points in my testimony, just highlight three claims—one, a claim about fact and fiction concerning single-payer arrangements.

Second, I want to say something about what I take to be the core features of single-payer plans in operation, and then, third, say something about what I could imagine being problems of adapting single-payer schemes to the United States.

Now, on this first point, fact and fiction about single-payer and, in particular, fact and fiction about Canada, I think I am in the lucky position of not having to address Canadian detail. You have had plenty of testimony already. I would want to wholly associate myself with what Dr. Scully has said and what I know Michael Rachlis has written. The only thing I would add to that is that we have in the United States, after 20 years of talk across the border, really very little appreciation of the most basic facts about Canada and we have a kind of hysterical discussion about anecdote after anecdote, and all I can say is that we have been lucky today to have testimony from people who know what they are talking about.

Let me turn from that to a quite different point. I find the discussion of single-payer itself actually misleading in certain ways. Michael Rachlis just said that single-payer, after all, only refers to a single source of funds. It is like describing an insurance or medical care financing arrangement by its plumbing. It has nothing to do necessarily with eligibility. It has nothing to do necessarily with scope of benefits. It has nothing to do necessarily with the competence of those who run it. It is an inadequate label.

What I would want to urge you to think about is putting the label aside for a moment and saying what are the characteristics of a decent operating system of health care delivery and finance, and then what would it take to take those characteristics and apply them in the United States, and let me go through three or four of them. There is not very much difference, by the way, at the level of principle between what I am going to say and what the President has said or what you say.

The first, I would say, is that we have few examples in the world of insurance or financing schemes working very well if they cover only part of the population; that is, universal schemes seem to work better, ones that put people in the same boat. Why? It is not simply because you have to have 100 percent of the group in the plan in order to make it work at all. It is that when everybody is in the same boat, politically there is much more aggressive monitoring that takes place over what happens. So universality here doesn't mean everybody has insurance, but universality here, understood this way, means that everybody has insurance under roughly the same terms, which is the key to monitoring.

The second feature that I think is absolutely crucial, and it is illustrated by Canada but not restricted to Canada, is that what the insurance or the payment covers is what ordinary people and ordinary physicians and nurses and hospital administrators think to be medical care. If you start segmenting what takes place and saying some things are in and some things are out, much of your fight about cost containment takes place at the boundary or the borders, what is in and what is out.

Most of the schemes around the world that have been successful in balancing costs, quality and access have a very broad conception of what is covered, but a very tight conception of what the budget should be that is available to pay for what is covered.

The third feature that I think is very important that was mentioned by Dr. Scully has to do with what choice is a choice about. In the United States today, there is a lot of discussion in the Clinton plan about choice of insurance plan. That is not the choice that

most people in the world in plans that work pretty well are concerned about. What they are concerned about is choice of caregiver and the caregiver's choice of a course of action that makes sense to the caregiver. I think it is terribly important to highlight that. Most plans of the OECD world that use either single-payer financing or some close surrogate have considerable choice of caregiver, particularly primary caregivers.

The fourth and last point I want to make is that all of these schemes have much more successful records of cost control than does the United States. As you know, we spend now over 14 percent of GNP on medical care. The closest competitor is Canada, just under 10 percent of GNP, and the rest of the OECD countries cluster between 7 and 9 percent of GNP. So our record on cost, while we use extensive cost-sharing, while we have extensive omissions in coverage, and while we have an extraordinary range of choice of insurance plans, is very poor on that dimension.

My last point related to that is this. Some people hold out the view that we are talking in the United States now about a competitive plan as an alternative to a single-payer plan. Well, I would like to emphasize that every single-payer plan in the world that I know of has intense competition among providers or among physicians and hospitals for customers, for patients.

The question is not whether there is competition in single-payer schemes. The question is on what basis is there competition, and if you have given prices for medical care that are equal in a jurisdiction, then people compete on real or presumed quality, not on price. Those are the elements that I would emphasize in single-payer schemes that combine into operational arrangements that produce more satisfactory results than we have got.

The last thing I want to turn is if I were using those elements as building blocks for the United States and I used Canada as an illustration of building blocks in operation, what would I say about the adaptation of Canadian experience to the United States?

I would emphasize three points. First, we have had a discussion here already about waiting times. I align myself much more with the characterization of waiting time as not a major issue in Canada, but there are arguments about it and there is certainly time for some high-technology interventions.

On the other hand, if you think about the difference between the United States and Canada spending 14 percent versus 10 percent, and given our supply of high-technology equipment, I can't imagine any waiting time problem at all, given our current level of technology in most of the areas people have been mentioning. That would be point number one.

Point number two—and this is a really serious problem—Canada's single-payer arrangement, as Australia's single-payer arrangement, as other close substitutes for that, Germany and France and Japan—all of those schemes are basically financed and run and pay on a fee-for-service basis. We have already got a good deal of pre-paid group practice and surrogates for it—IPAs, PPOs, that whole battery of things called managed care.

Now, I believe managed care includes devils and delights. Anybody who thinks that calling something managed care produces good management believes in tooth fairies. But the fact is we have

got a lot of care organized in group practice arrangements, and the Canadian model or any of those others is not well suited, without adaptation, to it. There are real problems of trying to mix capitation schemes and fee-for-service schemes that I think my colleagues from Canada would all agree with. I am not going to go into detail here, but just say that is an area of adaptation.

The third and last point that I would make is that we emphasize, those of us who write about medical care matters, that primary care should be the focal point of American reform and that we have got more specialists than any other place in the world. But the remedy that people think about, which is that we should increase the supply of primary care providers by having medical schools change their recruitment and retention of students, strikes me as an adaptation that is hopeless because we are talking about 10 years down the line.

It strikes me that another adaptation is one we actually could learn from Canada which Hugh Scully talked about. If we paid different for primary care services, the Canadian experience shows us that we will get more primary care services. You don't have to change the whole pipeline in order to get an adjustment in what doctors do.

Anyway, those are the three that I would mention at the outset. I think the thing I would emphasize, in conclusion, is that Canada illustrates a single-payer arrangement, but the key principles of so-called single-payer decent health insurance arrangements are far wider than Canada, and that the principles are common and are not special to our neighbor to the north.

Senator WELLSTONE. Thank you very much, Ted Marmor.

[The prepared statement of Mr. Marmor follows:]

PREPARED STATEMENT OF TED MARMOR

Mr. Chairman, my name is Ted Marmor. I am a professor of politics and public policy at Yale University's School of Organization and Management and a longtime student of health care issues.

I want to thank you for inviting to testify on the relevance of the Canadian experience to health care reform in the U.S. today. It is hard to imagine a more fitting time for someone like myself—who has spent much of my academic life studying the politics and economics of health care provision—to try to make practical use of academic knowledge. I will summarize my main points and ask you to make available in the record both my written testimony and the background materials I have brought along. Needless to say, I would be happy to answer any and all questions you and your colleagues have.

INTRODUCTION

The reform of American medical care is by now the most important topic on the nation's domestic agenda and the centerpiece of the Clinton Administration's plans for social policy change. The debate over the President's long-awaited plan is already extraordinarily contentious. It is a war of words, one whose outcome will affect the lives of all Americans.

The efforts to fix the troubled parts of American medicine present great opportunities for success as well as undeniable risks of disappointment. President Clinton's commitment to health reform in the 1992 election forcefully brought medical care to the nation's attention. The extraordinarily extensive and unprecedented effort by the President's Task Force on Health Care Reform generated intense interest in the details of what the Administration would propose and alternatives to it.

Like many others, I awaited eagerly the details of what the President envisions. But I—and the Health Care Study group I have helped to organize—have not waited to make our statement because the debate to date has already produced so much confusion. Press reports suggest that one of the major challenges the Administra-

tion's task force faced was to find terms for reform that resonate with the American public. "Purchasing cooperatives" apparently failed this test and were replaced by "health alliances". "Managed competition", it was found, means little to most Americans, leading to a search for another, more appealing label for the Clinton Plan.

It is certainly time to move the debate away from marketing labels and prepackaged proposals. In a hearing like this, my aim is to discuss the essential building blocks that make for successful reform. The first part of my statement will address that topic—the standards by which any reform proposal should be judged. Further debate about whether "managed competition","single payer", or "tax credit" approaches are best in principle is an arid exercise. The central question is what combination of policy and institutional changes will give Americans a workable, secure, and satisfactory set of medical care arrangements. To assess any of the competing proposals, the public needs clear and sensible standards, not further rhetorical confusion.

The second section of my testimony addresses the extent to which the Clinton proposal aims to satisfy these standards. As I argue, the President's principles are remarkably similar to those identified with single-payer plans in general, and Canadian national health insurance in particular. The third part of my testimony addresses two further questions about single payer proposals and the Clinton reform proposal. What, I ask, constitute the core elements of so-called single-payer models and what does the experience internationally teach us about the central and peripheral aspects of these models? Lastly, what should concern advocates of single-payer reform about the Clinton plan generally and more particularly the provision for states to choose such a model if so motivated.

STANDARDS FOR HEALTH CARE REFORM

Health care issues are complex, we know. Diverse and conflicting interests are at stake. Serious reform means breaking new ground, undertaking tasks with uncertain prospects. Legislative compromises are hard to foresee and policy consequences difficult to anticipate. Many conflicting arguments and claims of "fact" will be made.

Yet, the experience of other countries tells a great deal about what health reforms are possible and how to accomplish them. Defenders of our status quo cannot argue that a better system is impossible, because other nations provide universal health insurance for high quality medical care at much lower cost than we do. While research on health care leaves many questions unanswered, American experience and research also can teach us a great deal about how well particular reforms would work in the American context. We know far more today than we did ten years ago about what features of medical care Americans value, about the potential costs and benefits of managed care, copayments in health insurance, and fee schedules as well as the ways in which medical professionals allocate budgets. The standards outlined below follow from our shared understanding of this research and experience.

In an industry that accounts for one-seventh of the nation's output, there are countless stakeholders ready to use both argument and deception to protect their interests. In reforming a system of such huge size and complexity, it is all too likely that plans will work out very differently from what was intended. But, it is of enormous importance that the coming debate eventually result in successful change. To contribute to that end, we hope to help citizens navigate the mine field of "arguments" and "facts" about the President's proposal and alternatives to it. We believe the standards below address the questions of reform that really matter.

1) Universal Coverage

The United States can and should provide universal and broad health insurance coverage. No one should be without protection against the costs of illness, injury, and disease. That means health insurance should be portable, not depending on where one happens to live or to be ill. The costs of health insurance to individuals should be independent of their health risks, their prior ailments or afflictions. In short, there should be community?rated, not experience-rated payment for health insurance.

2) Broad Benefits

Health insurance benefits should include all ordinary and necessary medical care. This standard is clear: coverage of acute and chronic illness, of ordinary visits to doctors, of preventive care (like immunizations), and of substantial expenses for prescription drugs. Some coverage choices are necessarily less certain, but should in our judgment include those benefits for mental health, dental, and long-term care which most clearly require medical skills and are least vulnerable to abuse.

Health insurance must be free of obfuscation, nasty surprises, and senseless exclusions. In a reformed system, patients, payers, and medical providers should have little trouble telling who is covered for what.

3) Fair and Adequate Financing

Financing should be fair and fiscally responsible. It should be broad-based, spreading the costs of care, not concentrating them on the sick or the unlucky. The instruments of finance are many—general tax revenues, value-added-taxes, premiums for employers and employees, our-of-pocket payments—but the principles of fairness and reasonableness are few.

First, the costs of insurance should not vary with the medical risks that individuals face. Second, financing must be compulsory to avoid adverse selection. (Adverse selection refers in this context to situations where healthier citizens disproportionately forego or seek cheaper insurance, leaving the sicker to fund more expensive plans.) Thirdly, money for medical care should be raised in- a way that is predictable, easy to collect and simple to administer. It should limit incentives to reduce employment, or to avoid work. It may be more acceptable to the public if health insurance financing is earmarked, a consideration favoring payroll contributions. But a number of financing sources can and do meet the tests of fairness and reasonableness.

4) Firm and Enforceable Controls on Medical Spending

Coverage cannot be guaranteed, and financing cannot be stably provided, if the growth of medical costs continues to outpace substantially the combined rates of national inflation and productivity growth. No cost containment strategy, we acknowledge, is even close to perfect. Yet experience in other countries—and some American states—shows that cost growth can be controlled much better than we have thus far managed to do.

Control requires, international experience tells us, three crucial features: overall budget limits, regular negotiation about payment terms, and substantial bargaining power for those representing insured citizens. The particular form these features assume varies enormously; it is their joint presence that is decisive.

Voluntary cost control is self-contradictory. Expecting doctors, nurses, and hospitals to give up future income voluntarily is about as sensible as expecting hockey players to be nice. Voluntary controls with more certain regulation as a "backup" simply promise to delay restraint. Given the explosive growth of health costs, neither the federal budget nor American pocketbooks can afford delays in effective cost constraints.

The incentives and authority to control costs can be built into the basic scheme of medical finance. If multiple insurers bill through a central processing unit, for example, that both reduces administrative expense and provides superior records for identifying troublesome practices by individual doctors, clinics, or hospitals. Cost control is much easier and more certain if it concentrates on overall budgets and levels of payment rather than on the management of individual episodes of patient care.

5) Encouragement of Medical Professionalism

Many attempts to manage care treat physicians as suspect persons, more the problem with the system than key figures in improving the quality of American medicine. We believe reform must respect the professional role of physicians.

Physicians and their clinical colleagues have a professional obligation to analyze the effectiveness of their diagnostic and treatment practices, and to disseminate that information. Such information should, where possible, be used to reduce the amount of unnecessary or inappropriate treatment—and to increase appropriate care. But such efforts should be viewed as means to increase quality and efficiency in any medical system, not as a magic bullet which makes other reform unnecessary.

Professional autonomy, it should be emphasized, does not extend to charging whatever one wishes. But workable cost controls rely upon, rather than override professionalism. Cost controls should sharply reduce financial incentives that distort care, and then allow doctors to allocate resources according to their professional judgment. The opposite approach, efforts to control costs through detailed rules and review by outside parties, has produced much consternation and little cost saving. There is no substitute for the trained and sensitive judgment of a good physician, or team of physicians, about individual patients. No reform that ignores physician concerns about autonomy will prove workable over time.

6) Simplicity

A reformed medical system should be much simpler than the one we now have. Its rules of operation surely should be comprehensible. Patients and providers alike must know how to use the system, where to complain, and whom to blame if something goes wrong.

It should be simple to use, but simplicity in operation requires simplicity of design. If all people are covered under basically the same terms, a simple health insurance care should do. If and only if plans meet a national standard will it be easy

to ensure portability, so citizens are covered even if they are traveling, become unemployed, leave school or change their residence. Simpler coverage allows simpler billing. Reform should not create complexity that forces people to make impossible guesses about the kind of health insurance coverage they need (or might do without). Above all, cost control should not make handling claims when ill a hassle.

7) Accountability

We should also expect reform to make American medicine more accountable than it is now. The central question is whether reform makes clear who can be called to account for the cost, quality, and accessibility of care and how that will take place.

There are multiple problems of accountability. No single form of control or redress, such as market-like signals whereby patients leave insurance plans they dislike, will be sufficient. Better information about the quality and accessibility of care can help patients choose. But populations differ greatly in their use and understanding of medical care, and developing this information is easier said than done. We have few lessons from experience and too many exaggerated hopes for patient guides to good medical care.

Certification of professional competence—from licensure to continuing medical education—must be strengthened, but can only yield general assessments of quality. Even as we strengthen professional discretion, we must improve mechanisms of redress in individual cases of abuse. Our current malpractice system favors compensating victims over prevention of future victims. We must develop clearer, more balanced ways for individual patients (and their advocates) to present grievances; to provide effective responses; and to ensure justice to those providing care as well. That should involve developing institutions of consultation, negotiation, and redress that must vary with the enormous geographic, economic, and cultural diversity of the United States.

If providers are to be accountable, so must be the system as a whole. No system is perfect, or permanent, or self correcting. There are no right answers to some questions, only hard choices. Therefore we should expect on-going negotiations and adjustments, as the public and hospitals and doctors and other participants discover new problems and possibilities. If we expect officials to be responsible for our satisfaction with the daily operation of health insurance, they must have the means and technical competence to evaluate and respond to difficulties. Reform cannot stint administrative competence.

8) A Reasonable Burden of Change

No reform will work, no matter how clever in design, if it suddenly requires patients and physicians to behave daily in ways they strongly want to avoid.

This standard is especially important in judging proposals that claim universal coverage at reasonable cost can only be achieved by quickly reforming the delivery of medical care. The more idealistic model of "managed competition", for example, contemplates the creation of a system of competing, group- or staff-model, health maintenance organizations (HMOs).

It is highly unlikely that this form of managed competition could be implemented soon enough to produce the desired cost savings unless the government essentially coerced people into such plans. The legitimate costs differences between such group practices and fee-for-service medicine have not switched patients into health maintenance organizations at anywhere near the required rate. It is difficult to imagine that the marginal financial incentives that have been proposed would do the job.

The reason is choice: patients want to preserve their choice of doctor (or hospital). We should be skeptical of systems that, by emphasizing cost considerations, would first reduce choice for patients. The growth of model HMOs should be encouraged and their growth may well contribute to cost control in the longer run. But to rely on patients and providers to change their behavior suddenly and to flock to join such organizations would make implementation, and the success of reform, dependent on an unprecedented development.

There are logical stages of reform. The reform of how medical care is financed and paid for is far simpler than reform of how it is delivered. It asks far fewer people to change behavior, and the behavior it asks them to change is less important to them. Most people, we feel sure, would rather change their insurance company than their doctor.

CONCLUSION

These are the standards for acceptable reform our health care study group has developed. Even if planners satisfied these standards, there would be ample grounds for less-than-cordial debate. Nor would development of political support for reform be straight forward, or implementation easy. Even after a plan is adopted, constant

negotiation and adjustment—both within plans and across the whole system—are to be expected.

II. Patterns of Fact and Fiction in the Use of Canadian Experience with Single-Payer National Health Insurance

As of this writing (October 1993[1]), U.S. policy-makers inside the Beltway have yet to grapple seriously with single payer models in general or Canadian experience in particular, despite growing interest around the country. During the campaign of 1992, now President Clinton did repeatedly cite the superior experience of other industrial democracies in controlling health costs, including Canada's Medicare. But he seldom embraced straightforward forms of national health insurance as a model. Indeed, one noticed his innocent repetition of a number of the myths which the American Medical Association and the Health Insurance Association of America (HIAA), among others, relentlessly disseminated during the most recent period of political interest in Canada from roughly 1989 to early 1992. Nonetheless, Canada has played a crucial if not well understood role in American debates over health care since the late 1960s and, even today, has an influence that is all too easy to overlook now that the nation's media are preoccupied with understanding the newest slogan for reform, "managed competition."[2]

The history of US interest in Canadian national health insurance is mostly a story of episodes of extensive public attention (1970–74; 1989–92), punctuated by longer periods of inattention. Before the 1970s, very few health policy analysts in the United States knew very much about Canadian experience or paid much attention to it. Among the exceptions were scholars like Cecil Sheps and Sam Wolfe, Canadians who had participated in Canada's reforms during the postwar period, had emigrated to the United States and continued to write about Canadian experience and its relevance to the United States. But the number was small, as I learned when I turned to North American comparative studies in the late 1960s.

But that was not to remain true in the 1970s. Early in the decade, Senator Ted Kennedy was but the most prominent example of the many politicians who traveled north to marvel at Canada's relative success and celebrated its lessons upon return. In 1973–74, national health insurance was firmly on the American political agenda and the Kennedy-Corman plan of that period owed much to the Canadian model. The 1975 book Canadian National Health Insurance: Lessons for the United States was widely read in academic and policy circles and Canadian authors, like Bob Evans of the University of British Columbia, became a regular participant in seminars and conferences south of their border.[3]

Canada's Medicare faded from public view in parallel with the fading of national health insurance from the U.S. national agenda. It is easy to forget that Jimmy Carter ran for President partly on the promise to enact national health insurance and there was enough interest in the late 1970s to warrant a steady flow of papers and occasional books. But the Reagan years were tough ones for North American comparativists. The frustration with stagflation—and the same neo-conservative forces that brought Mulroney to Canada—had their effect. The crises of the welfare state—and the call for de-regulation and the retrenchment of the state—brought pro-competitive arguments to the fore.[4] It took until 1989 before a serious interest in Canadian Medicare re-appeared. And, then, it emerged in a familiar manic-depressive cycle of initial excitement, manic coverage, and depressive reaction.

The precipitants of excitement are easy enough to identify. In 1989, Lee Iacocca, the head of Chrysler, and his board member and former Carter Cabinet officer, Jo-

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[1]This section of the testimony draws from the introduction to my recently published article "Health Care Reform: Patterns of Fact and Fiction in the Use of Canadian Experience", The American Review of Canadian Studies, Vol. 23, Number 1 (Spring, 1993).

[2]For a discussion of the contemporary debate over universal health insurance—and the odd place of "managed competition" within it—see the special issue of the Yale Law and Policy Review, Vol. 10, No. 2, 1992 and, in particular, the essay by Marmor and Barr, "Making sense of the national Health Insurance Debate." For a thoughtful discussion of the ideas of managed competition, see the last chapter of Paul Starr's The Logic of Health Care Reform, (Whittle Publications, 1992) and the essays of Starr and Marmor in The American Prospect, Winter 1992, Number 12. The literature on managed competition is extensive, but almost entirely hortatory; the journalism is puzzled and confused.

[3]Andreopolus, ed., Canadian National health Insurance: Lessons for the United States, (New York: John Wiley and Sons, 1975). The sequel to this work, Medicare at maturity, edited by Evans and Stoddart, (University of Calgary Press, 1984) was to become far less well known, published as it was during the Reagan years.

[4]For an elaboration of this argument, see Marmor, Mashaw and Harvey, America's Misunderstood Welfare State: Persistent Myths, Continuing Realities, (New York: Basic Books, 1992), especially Ch. 6; for more specific North American medical care comparisons, see the chapter by Barer and Hertzman in the forthcoming book, "Economic Security and the Aged in North America", a project supported by the American Donner Foundation.

seph Califano, published admiring editorials in the New York Times. Though nothing new was said, new figures of authority—business leaders—were arguing that Canada's form of national health insurance combined broader coverage and less costs than in the U.S. and, furthermore, that our persistent medical inflation was a serious problem for the competitiveness of the nation's major corporations. What then followed was a torrent of attention—from squads of Congressional figures visiting Montreal, Toronto and Vancouver to numerous newspaper features, from PBS's 1990 documentary Borderline Medicine to the persistently favorable reviews of Canadian experience by a new reform group within American Medicine, Physicians for a National Health Program (PNHP). All three television networks did specials on Canada's experience with Medicare and, for a time, Canadian experts were inundated with requests for interviews, information, and expertise. Had the 1992 presidential election been held in 1990, Canada's experience with national health insurance would have figured prominently in it.

The forces of reaction, however, had ample time to develop. Led by the AMA initially, the critics of Canada's "socialized medicine" used the full arsenal of propagandistic techniques to question both Canada's performance and its relevance to the United States.[5] The HIAA came to take the lead role here, shamelessly blasting Government Accounting Office's 1991 report on Canadian experience with national health insurance as partisan."[6] A pattern emerged: any news story in Canada about waiting lists, a disappointed patient or physician, or squabbles about the availability of funds for doctors, hospitals, or new capital equipment quickly found its place in the testimony of the HIAA, the American Farm Bureau Federation, and right-wing think tanks like the Heritage Foundation. Naive journalists, using the shopworn technique of quoting "both sides", gave ample space to both the celebrators and the detractors, thereby repeating myths without analyzing them. The public paid less attention to this than did the politicians, overwhelmingly stating their approval of the Canadian program pollsters described to them. But, the growth of a vigorous pro and anti-Canada lobby took its toll on risk-averse presidential candidates.

All of this was played out in dramatic form during the Democratic primaries of 1992. Senator Kerrey, an advocate of national health insurance, advanced a plan similar to Canada's program, but increasingly distanced himself from explicit citation of the model north of the border. He came to talk, as did others, of the need for an "American solution" for an "American problem", hoping to avoid the knee-jerk nativism that rises close to the surface of American public life whenever it is claimed that another nation has something to teach us. And with that came additional commentary that, in any event, Canada was really quite different from the United States. Seymour Martin Lipset, a thoughtful and subtle commentator on North American similarities and differences, had recently published Continental Divide, a book which carefully and sensibly addressed the comparatively modest, but undeniable differences across our borders. But advocates of market solutions to medical problems seized on this and other Canadian materials to argue that however good Canada's Medicare might be, it was the product of a nation committed to "peace, order and good government," not to the U.S.'s individualistic creed of "life, liberty, and the pursuit of happiness."

The mixture of superficial programmatic and cultural analysis has taken its toll. Bill Clinton heard more about Canada's troubles and its cultural distinctiveness than he did about how Canada's comparative success reflected policies and structures that international experience validated as crossnational lessons. And, in this, he was not helped by Canadians who, in an understandable concern for differentiating themselves from the U.S. and fearing for national health insurance's fate global budget limits, state involvement, comprehensive benefits, and managed care. All but the last mirror the central principles of Canadian national health insurance! Moreover, the pairing of global budgets and universal coverage reflects the seeping into the US reform mind of precisely the key elements analysts of Canadian experience have been emphasizing for two decades. It is true that the decreased appeal (to politicians) of the single payer model has discouraged many citizen activist groups who know the American public is well-disposed to Canada's program and are anxious to

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[5] In fairness, the AMA retreated from its propaganda attacks in 1989 after receiving serious criticism from both Canadian physicians and American groups. By 1992, the AMA was taking a far more considered position on universal health insurance, leaving the HIAA as the leading pressure group critic of Canadian Medicare.

[6] The HIAA's role in disseminating selective information did not, however, go unnoticed. Consumer Reports, for instance, published a remarkable series of articles on national health insurance during the summer of 1992, including a portrayal of Canada as a troubled but indisputably attractive model and a set of sharp criticisms of the Canadian mythmaking disbursed by the HIAA and other groups: "The Search for solutions," Consumer Reports Magazine, September 1992.

rid America of the wasteful administrative expense 1500 private health insurers represent. But it would be a great mistake to overlook the impact that Canadian experience has had or to believe that the labels used to refer to a reform plan illuminate either its central features or the forces that produced them. At the very least, this is what comforts me as I testify yet again on fact and fiction across the North American medical border.

III.Single payer models: Core and Peripheral Features

Single payer systems have, at least by comparison with the current non-system in the United States, produced relatively more restrained health care expenditures in the last fifteen years. But what about the single-payor structure is at work? Why should this cross-national result be the care? Without knowing that, there is too much of a black box quality about the explanation. We have heard the results from the Canadian experts here today, but there is more to explore regarding the reasons.

This is a complicated subject in political economy, and I can only sketch the outline of an answer. But what I would emphasize is the distribution of the winners and loser from increases in health care expenditures. Everywhere among the industrial democracies, there are pressures to spend more on medical care; it is presumed, thou with increasing expert dispute, that more medical care means better health, So the question is how expenditures for what is presumed social improvement are constrained. In pluralistic systems of finance, each payor is interested in her health costs, not the costs of health care. Any cost shifted represents a 100 percent gain to that payor; hence the competition in such systems to have someone else pay whenever possible. In the United States, that means attention to costsharing by patients (shifting costs backward), government requiring private insurance to pay for some Medicare beneficiaries actively at work (shifting costs sideways), and the reverse, as when companies reduce or eliminate their health benefits and turn employees into potential charity cases for local hospitals and doctors. Under such systems, total costs are reckoned at the end of the year, discovered, not chosen. The results are expensive, as the American experience testifies.

It also testifies for the single-payor solution of monopsony bargaining over the price and volume of heath care in a political jurisdiction. Single payer systems rest on the notion that, because every marginal dollar of expenditure for health care is income for identifiable and organized health care providers, the payor side must have correspondingly concentrated interest in those marginal dollars to balance those stake-holders who regard each unit of expenditure as benefit, not a cost. The balancing of these interest does not man health care expenditures will assume a particular level and stay there. But it does appear to provide the necessary conditions for establishing some equilibrium in expenditure levels. (Whether some system will emerge that can "harness" competitive forces to improve health care performance is at best speculative. What has emerged has not and Canada provides another illustration of the general type that throughout the industrial world has, in fact, restrained costs.)

The question of cost control has been answered at the macro level, in Canada and elsewhere. At a micro level, it involves the questions of medical care supply and payment details. In Canada as in other nations, the supply of physicians has increased by over 70 percent in recent decades, strengthening pressures for increased utilization and expenditures.

Regarding hospital supply, the Canadian experience is best thought of in connection with more recent American experience. The trend line of length of stay is downward in both the United States and Canada. But it is clear that there are very substantial variation in length of stay and therein lies a clear lesson for others wondering about how much to augment the supply of hospitals in advance of expanding financial access to care. The relevant lesson seems something like this: the reduction of the supply of hospital beds may well be the single most important prod to primary and preventive care that lies within a nation's range of policy-relevant tools. How long one must stay in hospital varies not just with the relevant medical condition but the availability of alternatives to hospital use. This is relevant not only to the beginning of life—births—but to the treatment of the frail old. What Canada shows beyond doubt is that an ample supply of hospital beds, combined with increases in the old, produces a substantial increase in the use of hospital beds for what is nursing home care. (Beyond that, there is simply wasteful use of amply supplied hospital beds: e.g., patients coming in one or two days before surgery to "get ready.")

Thus, it is appropriate to consider the redistribution of health care supply across communities. Perhaps it is safe to say that the huge distances and spread out population of Canada do not present obvious parallels to the circumstances of other nations.

Turning to methods of payment for health care, the global (as opposed to line-item) budgeting of hospitals as against the per diem method of insurance funding that had been the pre-NHI norm in the west has been strongly endorsed. There are no panaceas here and each funding mechanism has the vices of its virtues. But among the virtues of global budgeting is ease in knowing what is committed to health care—particularly its most expensive component. Global budgeting in Canadian practice has involved a trade-off between the increased predictability (and controllability) of hospital spending and greater autonomy of hospital decision-making about how to spend the global budget. There are ample means in the Canadian system to restrain capital expenditures (separately budgeted) and additional means through decisions on operating costs that will be included in the global amount. But analysts seem now to agree that Canadian use of hospital beds (as opposed to the technological use rates within hospitals) has been unnecessarily ample. This is but one example that Canadian performance on health might be improved by less rather than more expenditure.

In sum the Canadian experience portrays a medical care system that works, that delivers decent care to an entire population at outlays that, while always pressuring decisionmakers, are relatively stable and quite amazingly popular. If ever there was an example of a public institution that was both expensive and admired, it is Canadian national health insurance. None of these features depend on peculiarly Canadian values in politics, society, or economics. The particular institutional details do, of course, show their origins, but other nations could extract the essential features of the Canadian system and adapt them to their institutional architecture. Whether they would have similar effects depends on whether the new user differs in some significant way from those nations whose practices conform to the Canadian pattern as well.

CONCLUSION

To find the right combination of effective and acceptable reform, we need to explore what our historical experience—and the lessons of other regimes—tells us about desirability and feasibility. In doing so, we ought to ponder the widespread use in other systems of politically accountable single-payer methods of financing care. And we ought as well to wonder why polities both similar to and different from our own have come to essentially the same conclusion about the necessity and acceptability of single payer systems of countervailing power in modern medical care financing.

Senator WELLSTONE. We were going to try and finish at 4:30. With your indulgence, I thought we might just go a bit beyond that.

Dr. Walker, I feel like I should give you, first of all, an opportunity. I was reading your facial expressions and the nodding of the head, and I know that you want to respond. I wonder whether we couldn't go back to some of your figures on waiting times, some of the responses from Dr. Scully and Dr. Rachlis, and maybe you might want to respond to what they said. I think it would be good to have a bit of exchange of views on this.

Mr. WALKER. Sure. Well, let me first of all say that our waiting list measurements are the only ones that are conducted in Canada on a comprehensive basis across all the provinces, and we have been asking other people to provide us with information. To the extent that they do provide us with information, we incorporate it in our surveys.

So, for example, many of the data that are included in here on cardiac care, which has been discussed by two of the other panelists, in fact, come from hospital-based waiting lists and are, in fact, reflective of the committee in Ontario that came up with the categorization methods for deciding who should be on an elective, who should be on an urgent, and who should be on an emergent waiting list.

Notwithstanding that fact, we still find in our survey—and we invite people; we are trying to find out real information here. In

spite of the fact that people like Dr. Scully and Dr. Rachlis say they don't think these numbers are accurate, they don't offer any alternative numbers. Unless we are going to discuss numbers versus numbers and measurement versus measurement, I don't see how we can have a sensible discussion about whether we have a problem in Canada or not.

My concern is—and I think you should be concerned about it as well if you are thinking about any system that involves budget caps—is what will be the implications in terms of rationing for your system. As I pointed out, my interest in waiting list measurements in Canada came from the observation that the British health care system, which has been very successful in controlling or capping the overall cost of health care, has produced very, very long waiting lists, and I think waiting lists that really are unacceptable.

The question is are those kinds of waiting lists going to come to Canada. The evidence we keep accumulating year after year and making available to people——

Senator WELLSTONE. You are talking about the United States, you mean?

Mr. WALKER. I beg your pardon?

Senator WELLSTONE. Are those waiting lists going to come to the United States? Is that what you were——

Mr. WALKER. Well, the question is are we going to get in Canada, first of all, the waiting lists that are in Britain.

Senator WELLSTONE. I am sorry.

Mr. WALKER. In other words, is there some inevitability about the way in which—if you have a single-payer system, do you inevitably get this kind of response? We simply make the data available, and hopefully the data will become more accurate as time goes by when people like Dr. Scully will provide us with critical assessments so we can improve the data.

But I must say I find it very difficult to listen when people say, well, your data are wrong, but don't provide any alternative measurements that we might improve them by, and we have adopted every single suggestion for improvement that people have offered.

May I, while I have the microphone, just make one comment about malpractice because in looking at the proposals which you have before you in the United States at the moment, it seems to me the only proposal you don't have is the one that is effective in Canada, and that is the one that limits the award for pain and suffering. The supreme court in Canada has set limits on the amount of the payment that can be made for pain suffering.

As I understand it, the Clinton proposals, and I don't know of any others that have been made along these lines, suggest everything else except a cap on the award for pain and suffering. It does seem to me if you are going to learn from our experience, at least with regard to controlling that particular cost, you should focus on the award for pain and suffering in controlling your malpractice costs.

One final point, and that is about rationing in favor of the rich and powerful. One of the things that we have found in our research, looking at who is caused to wait under our health care system, suggests very strongly—and this, by the way, is a view that is shared also by researchers at the University of British Columbia

who are very strong devotees of the Canadian health care system—that people who are well-connected, people whose incomes are high, in particular those who are in the top two income groups in our normal statistical ranking of incomes, wait less long for health care in Canada than people who are in lower-income groups.

Senator WELLSTONE. Let me try, if I could, to just get a response because we are going to run out of time, if that is all right.

Dr. Scully.

Dr. SCULLY. Thank you, Mr. Chairman. Two quick responses.

Senator WELLSTONE. I apologize for the interruption. I just know we have about 5 minutes to go.

Mr. WALKER. No, no. I understand.

Dr. SCULLY. The point I tried to make in my presentation is that with the system that we do have in Canada, the gap between what is available to those who have and those who have not has been narrowed more successfully than any other system that I am aware of in the world. I didn't pretend that everybody was equal under all circumstances.

With regard to waiting lists, Dr. Walker, the alternative information is that for emergencies, certainly, in cardiac care in Ontario where I represent all of the cardiac surgeons in Toronto in discussions with the province, and therefore 20 percent of the cardiac surgery in the country, the waiting time for emergencies is zero. It gets done. I don't know what you were doing at 3:00 in the morning, but I was replacing a valve and doing a quadruple bypass until 4:00 in the morning before I got on the plane to come down here, and that patient had presented in the coronary care unit 2 hours before that patient was in the emergency room. That is the way we try and operate, and that is the way you operate as well in the United States with emergencies.

So far as the urgencies are concerned, that is defined as something that needs to be done under 7 days with international criteria. The average waiting time is 5.4 days, Dr. Walker. I would be happy to provide that information for you. So far as elective surgery is concerned, when it comes to cardiac care, the average waiting time now in the province in Ontario, depending on the surgeon, is between 2 days and 4 weeks, maximum.

Mr. WALKER. Our figures don't disagree with that, but the point is that Ontario is not typical of Canada. That is the problem, Hugh.

Senator WELLSTONE. Dr. Rachlis.

Dr. RACHLIS. If I could say that if Ontario is not typical of Canada, then the United States is not typical of Ontario, and I would strongly support what Dr. Marmor had to say that with the amount of money that you have put into high-tech medicine, it is going to be another 200 years before you have any waiting problems, I am sure.

I would like to make two quick other points in response. One is something that is in your document from the National Center for Policy Analysis about poor people in Canada, in fact, being worse off with budget caps and single-payer. I think that is blatantly untrue. Using the example of coronary artery bypass surgery, an article by Jeff Anderson, a University of Toronto physician and researcher, from JAMA of this year, shows that in Canada poor people who have more heart disease than rich people are more likely

to get heart surgery in Canada. They are about half as likely to get heart surgery in New York State if they are poor, compared to being rich.

The final point about malpractice—you would be able to eliminate a major portion of your malpractice problem in this country if you had a single-payer system because my understanding is that one of the major reasons why patients sue, of course, is that is the only way they can get coverage for future health care. With an injury from medical care, whether it was due to negligence or not, they have a preexisting condition which will, of course, prevent them from getting insurance after that unless they can get the resources through a lawsuit.

Senator WELLSTONE. Mr. Marmor, this would be the last question. I would kind of like to see whether you could try and, as you usually do with a considerable amount of eloquence, tie some things together. What would you see as kind of, if you will, a common ground—as the debate goes out into the country outside of Washington and more and more people have a chance to study the plan and talk about it and meet with their representatives and Senators in the best of representative democracy—between the President's proposal, forgetting the labels—and I think you are right to tell us to forget the labels and let us look at the final plan—and what is in the American Health Security Act? I mean, where do you see the convergence?

Mr. CMARMOR. The common ground that might emerge if there was a serious national debate?

Senator WELLSTONE. That is right.

Mr. CMARMOR. I actually think we are very close to common ground, but we are prevented from seeing it by the noise that is created in the media and the noise created by the dense jungle of interest groups that have now had 9 months to prepare every imagined argument in the world to confuse Americans about what is at stake.

The four that I think there already is common ground about are these. I think there is no difference between what the public wants and what the President says about universal coverage, but I think there is a little difference about the pace of change toward putting people in universal arrangements which are common. So the common ground there is universal talk, and there is a difference about pace and the meaning of universality that is not a huge difference.

I think on comprehensiveness of benefits, there is actually some difference in the details and no difference in the aspiration. But I think as Americans came to know more about the complicated cost-sharing arrangements that are built into the Clinton proposal, common ground will move in the direction of less complicated cost-sharing.

On the question of public accountability and who is to be answerable for the balancing of cost, quality and access, I think there is common ground already on the aspiration for accountability, but since the Clinton plan has invented a name for a new institution that is now called health alliances—it was called health insurance purchasing cooperatives—it is hard to have common ground between an aspiration and a fact. I think we are going to work it out, and my guess is that the result will be something like this, that

to the extent the Clinton plan emerges as one that genuinely permits a single-payer option in the States, that will take on the language of health alliances, except there will be a single health alliance in a State. We will have, in short, agreement that there ought to be an accountable body, but we will have some disagreement about how many there ought to be in the States.

Fourth, I guess I believe that the dissimilar grounds will maintain themselves over cost containment, and the only common ground I can believe there between those who are devoted to the proposition that competition among plans is the sufficient and necessary condition for cost control and those, like most of our panel members today, who believe that a concentrated financial authority is the best—the only common ground I can believe that will emerge there will be the possibilities of State choice.

I don't think we will have agreement on the national level about one or the other, but I think we may have agreement that one or the other ought to be an option to sub-national jurisdiction. So, roughly, that justifies my proposition that after years of talking about Canada and then dropping off the face of our discussion, we really are producing a kind of Canada-in-drag debate in which I have just described five of the Canadian principles for you.

Thank you.

Senator WELLSTONE. Very quickly, Dr. Scully.

Dr. SCULLY. Yes. Mr. Chairman, I think as a Canadian who is a student and an admirer of affairs American and a great fan of the energy and enthusiasm, I would like to congratulate you and your committee for having the hearings, and the courage of the President in articulating the principles, and have every expectation as a close spectator that you will work it out somewhere in the middle ground.

Senator WELLSTONE. Let me conclude by asking that a statement from the American Public Health Association be entered into the record.

[The prepared statement referred to appears at the end of the hearing record.]

Senator WELLSTONE. Dr. Rachlis, I understand that you have an article with you by a doctor from Saskatchewan who was active in the doctor's strike in the 1960's, but now supports the Canadian public system, and we would like to have that article included in the record.

Dr. RACHLIS. In fact, it is by Dr. Barootes, whom Senator Metzenbaum mentioned at the beginning of this hearing.

Senator WELLSTONE. We will include that in the record.

[The article referred to appears at the end of the hearing record.]

Senator WELLSTONE. Dr. Walker, Dr. Marmor, Dr. Rachlis, and Dr. Scully, I would like to thank you very much for your time and for your testimony. All of this sort of is just a part of what is a real historic discussion in our country and I hope it will lead to some very good health care policy. Thank you very much.

[Additional statements and material submitted for the reocrd follows:]

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PRESS RELEASE:

Hospital waiting list survey results cast doubt on the universality of national health care

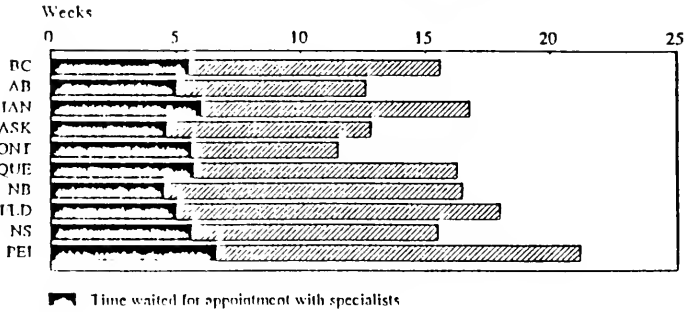
Ottawa>>>> The Fraser Institute today released the results of the first comprehensive measurements ever made in Canada of hospital waiting lists in all ten provinces. The measurements of hospital waiting lists are a result of information provided by 2,147 physicians in a survey undertaken during the latter part of 1992. The results published by the independent research organization show that some 177,000 Canadians are waiting for surgical procedures. The survey is the third conducted by The Fraser Institute—the first one dealt with only British Columbia, the second with a sample of five provinces—and represents an attempt to measure the extent of health care rationing in the different provinces. The data provide the possibility for comparing and contrasting the access that Canadians living in different areas of the country have to the most commonly performed surgical procedures.

In commenting on the results of the survey at a press conference in Ottawa today, Dr. Michael Walker, Executive Director of the Fraser Institute, noted that "This should be a very useful set of measurements to give Canadians better understanding of how their national health care system is working, and it raises some awkward questions about comparative performance in the various provinces." One point clearly emerges from the data: Canada's ten provinces do *not* have a uniform standard of access to surgical procedures. In Prince Edward Island, the province with the longest average waiting times, patients wait an average of 14.6 weeks (see Chart 1) for surgical procedures compared with the province with the shortest average waiting times, Ontario, where patients wait an average of 5.9 weeks for treatment. Between the provinces there is also wide variability (please see Chart 2) in access to the types of surgeries for which waiting lists are most frequent, such as reconstructive plastic surgery, orthopaedics (including hip replacement) and eye surgery (including cataract removal).

The survey also measured the waiting time for appointments to see specialists (see Chart 1). There was much less variation between the provinces in this category; five weeks is the standard waiting time. Orthopaedic surgeons appear to have the longest average waiting times overall, while eye specialists in P.E.I. have the longest waiting times of any particular speciality in any province.

A preliminary examination of the time patients wait in different parts of the country compared with the amount spent by government on health care in those provinces (Chart 3) suggests that there are basically two systems of health care in Canada. One is typified by the experience in British Columbia, Alberta, Saskatchewan, Manitoba, and Ontario, and the other by the experience elsewhere in Canada. The difference between the two systems is the average amount of spending per capita on health care. While there are exceptions, generally those provinces which spend $1,500 or more per capita on health care have shorter

Chart 1:
Total Waiting by Province
(Time from G.P. Referral to Treatment)

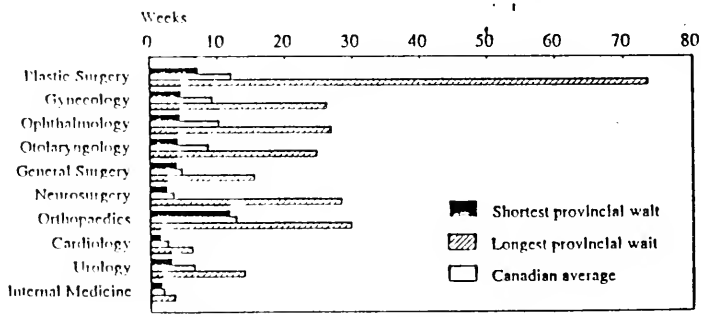


Source: Fraser Institute survey of specialists' waiting lists.

waiting times for surgical procedures than those which spend less. Ontario, which spends the most per capita, has the shortest waiting times. Prince Edward Island, which spends the least, has the longest waiting times.

"Hospital waiting lists are not a perfect indicator of health rationing in the provinces," said Dr. Walker, "but they are certainly helpful in pointing to areas of possible concern. The fact that there is a strong inverse correlation between spending on health care and our measurements of hospital waiting lists suggests that they may be a good indicator of rationing." Walker concluded, "Certainly it is the case that the decisions governments make about the amount to spend on health care have a direct bearing on the amount of time Canadians will have to wait for treatment. We hope that by releasing this comprehensive survey of waiting for health care we will encourage the development of more precise measurements of health care rationing and thus a more realistic discussion about how the health care system functions."

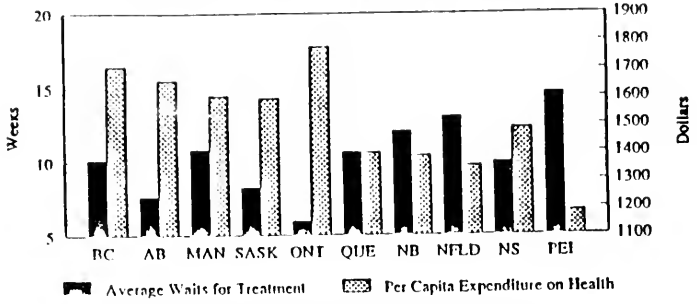
Chart 2:
Waiting for Treatment by Specialist
(Time from treatment booking to treatment)



Source: Fraser Institute survey of specialists' waiting lists.

Chart 3: Provincial Government Spending on Health Care Per Capita Versus Hospital Waiting Lists

(Time between booking of treatment and treatment)



Source: Per capita health care expenditure from "Public Finance Historical Data, 1965/66 - 1991/92," Statistics Canada (cat. 68-512).

Table 1:
Average wait (in weeks) for treatment by selected specialists in 1992

Treatment	B.C.	AB	SASK	MAN	ON	QUE	N.B.	NFLD	N.S.	P.E.I.
Plastic Surgery	11.3	9.5	14.1	11.2	2.2	9.7	19.1	73.6	14.4	—
Gynecology	9.6	2.6	9.7	14.2	5.5	5.0	26.3	4.7	10.0	24.9
Ophthalmology	13.9	8.5	23.4	20.5	12.6	14.9	20.6	4.3	18.9	26.9
Otolaryngology	7.5	11.1	4.2	7.3	5.7	2.0	8.9	24.8	18.2	7.7
General Surgery	8.8	4.9	7.5	7.0	4.0	6.1	6.0	15.5	5.7	1.01
Neurosurgery	7.1	7.3	3.5	7.3	6.6	28.4	2.6	—	7.1	—
Orthopedics	18.3	12.4	13.5	29.2	11.8	12.8	17.8	12.4	19.3	29.8
Cardiovascular (elective)	13.0	18.6	16.3	9.5	9.3	48.5	20	24.0	14.0	—
Cardiovascular (urgent)*	5.0	7.9	6.0	2.0	2.6	5.2	4.0	3.5	6.3	—
Urology	12.6	3.2	6.3	3.2	3.7	4.7	9.9	14.0	4.9	7.8
Interal Medicine	3.7	2.9	2.1	3.0	1.7	2.7	3.4	2.3	3.0	3.1
Weighted Average	10.1	7.6	8.2	10.8	5.9	11.2	12.0	13.0	9.5	14.6

* Weighted Average does not include pacemaker waits

Source: Joanna Miyake and Michael Walker, *Waiting Your Turn: Hospital Waiting Lists in Canada*, The Fraser Institute, 1993.

Table 2:
Average 1992 p[illegible]nt wait (in weeks) to see a specialist after referral from a G.P.

	B.C.	AB	SASK	MAN	ON	QUE	N.B.	NFLD	N.S.	P.E.I.
Plastic Surgery	9.6	7.3	8.9	9.7	5.3	5.3	7.8	12.0	11.8	—
Gynecology	3.2	6.1	4.5	5.9	5.0	10.4	6.7	4.5	7.9	4.8
Ophthalmology	3.3	2.9	9.0	10.2	7.6	6.9	6.1	6.0	6.4	27.0
Otolaryngology	2.7	8.9	2.2	5.1	4.7	3.3	5.5	2.2	7.2	2.0
General Surgery	3.6	2.4	2.4	2.6	2.7	3.0	1.6	3.3	3.8	2.0
Neurosurgery	7.1	15.0	5.7	12.0	11.5	4.7	4.0	—	3.5	—
Orthopedics	11.8	7.7	11.1	11.0	10.0	8.4	7.3	14.0	8.8	6.0
Cardiovascular Surgery	6.8	5.5	7.0	3.5	3.9	3.4	3.0	1.0	4.0	—
Urology	5.9	6.5	3.0	7.5	3.9	5.3	4.3	6.3	3.0	2.0
Internal Medicine	5.8	3.7	2.8	5.0	7.1	3.5	2.7	3.0	4.5	5.5
Weighted Average	5.5	5.0	4.6	6.0	5.7	5.4	4.5	5.0	5.6	5.8

Source: Joanna Miyake and Michael Walker, *Waiting Your Turn: Hospital Waiting Lists in Canada*, The Fraser Institute, 1993.

Table 3:
Survey of Physicians 1992—Estimated number of patients waiting by specialty

Treatment	B.C.	AB	SASK	MAN	ON	QUE	N.B.	NFLD	N.S.	P.E.I.
Plastic Surgery	539	430	346	195	1,200	1,252	175	335	105	—
Gynecology	1,905	1,620	935	1,265	3,682	2,456	1,642	288	720	273
Ophthalmology	747	673	746	571	4,332	4,391	659	43	917	125
Otolaryngology	1,170	1,717	352	413	3,424	1,605	429	999	757	56
General Surgery	2,459	1,372	941	848	3,914	4,866	588	952	671	167
Neurosurgery	928	710	161	182	2,216	4,135	57	—	238	—
Orthopedics	2,724	1,754	778	1,517	6,068	3,454	588	238	774	159
Cardiology	460	414	105	59	690	1,024	48	94	88	—
Urology	3,073	562	588	213	3,349	1,656	685	396	371	75
Internal Medicine	579	395	157	112	1,035	725	137	88	277	21
Residual	18,087	6,063	2,622	2,408	19,394	16,790	2,518	1,485	2,904	467
Total	32,671	15,740	7,727	7,783	49,354	42,354	7,526	4,978	7,822	1,343
Proportion of pop. (%)	1.1	0.7	0.8	0.7	0.5	0.6	1.0	0.9	0.9	1.0
Canadian totals	177,292	0.67%								

Source: Joanna Miyake and Michael Walker, *Waiting Your Turn: Hospital Waiting Lists in Canada*, The Fraser Institute, 1993.

Table 4:
Total expected waiting time (in weeks) from G.P.'s referral to treatment

Treatment	B.C.	AB	SASK	MAN	ON	QUE	N.B.	NFLD	N.S.	P.E.I.
Plastic Surgery	20.9	16.8	23.0	20.9	12.5	13.0	26.9	85.6	26.2	—
Gynecology	12.8	13.7	14.2	20.6	10.5	15.4	33.0	9.2	12.9	29.2
Ophthalmology	17.2	11.4	32.4	30.7	20.2	21.8	26.2	10.5	25.3	53.9
Otolaryngology	10.2	20.0	6.4	12.4	10.4	10.3	14.4	27.0	25.4	9.2
General Surgery	12.4	7.3	9.9	9.6	6.7	9.1	7.6	18.8	9.5	13.0
Neurosurgery	14.2	22.1	9.2	19.3	18.1	33.1	6.6	—	10.6	—
Orthopedic	30.1	20.1	24.6	40.2	21.8	21.2	25.1	26.1	28.1	35.8
Cardiology*	19.8	24.1	23.3	13	13.2	51.9	23.0	23.0	18.0	—
Urology	18.5	10.2	9.3	10.7	7.6	10.0	14.2	20.3	7.9	9.8
Internal Medicine	9.5	6.6	4.9	8.0	8.8	6.2	6.1	5.3	7.5	8.6
Weighted Average	16.1	12.6	12.8	16.8	11.5	16.3	16.5	18.0	15.5	21.2

*Elective surgery

Source: Joanna Miyake and Michael Walker, *Waiting Your Turn. Hospital Waiting Lists in Canada*, The Fraser Institute, 1993

Waiting Your Turn: Hospital Waiting Lists in Canada, 3rd edition, by Joanna Miyake and Michael Walker, published May, 1993 is available from The Fraser Institute. Call Bev Horan at (604) 688-0221 or (416) 363-6575 or fax your order to (604) 688-8539 or (416) 601-7322.

Michael M. Rachlis MD MSc FRCPC

The Canadian Experience with Public Health Insurance

Executive summary

During the last few years, the Canadian health care system has suffered from a well-funded attack by American interest groups. Typically, there are stories told of long lines for high technology services. In 1992, President Bush claimed that Canadians had to routinely wait six months for heart surgery and couldn't choose their own doctors. Newt Gingrich, Republican leader in the House of Representatives has claimed that it is illegal for Canadians over 65 to get many operations. Not to be outdone, Democratic presidential hopeful, Paul Tsongas asserted last year that he could not have received his autologous bone marrow transplant in Canada in 1986. None of these assertions are true. However, the Canadian system does have its problems and a careful study of the Canadian system is essential for Americans to make wise choices about the future of their system.

Canada's health care system faces a similar set of problems as do the health care systems of other industrialized countries including the US. However, the US has, by far, the most serious problems with costs and access. The major problems identified with Canada's system by a series of recent government reports include:

1. Too much focus on curative medicine as opposed to health promotion and disease prevention.

2. Inefficiencies due to the organization and financing of the system. For example, Canadians overuse institutional services compared with community services. Also, the predominant method of physician payment is fee-for-service.

3. Inadequate quality assurance leading to the provision of inappropriate care. There are few explicit written standards. There is little monitoring of physicians, even by other doctors.

It is important for Americans to realize that these problems are specific to the model of single-payer plan implemented by Canada. None of these problems are inherent to public health insurance.

The main lessons for Americans from Canada's health care system are:

1. The cost savings from a single-payer plan are real. Canada's system is more than 3% of Gross Domestic Product less costly than the American system. The savings are due to factors associated with a single-payer plan, including lower administrative costs and reduced hospital and physicians costs.

2. Canadians have better access to almost all health services than do Americans. Canadians use more physicians' services and hospital services than do Americans.

3. Canadians, on average, have less access to high-technology services than do well-insured Americans. However, it appears the health impact of this decreased access is minimal, and so far, anecdotal. Furthermore, uninsured or poorly insured Americans representing perhaps one-third of all Americans, have less access to high-technology services than do Canadians. There is considerable documentation of the adverse impact on the uninsured and poorly insured in the US.

4. The major problems of Canada's health care system have little or nothing to do with single-payer financing. The problems relate to the method of organization and financing of the largely private delivery system. The US could implement its own national health program and avoid Canada's difficulties.

Introduction:

During the last few years, the Canadian health care system has suffered from a well-funded attack by American interest groups. Typically, there are stories told of long lines for high technology services. In 1992, President Bush claimed that Canadians had to routinely wait six months for heart surgery and couldn't choose their own doctors. Newt Gingrich, Republican whip in the House of Representatives has claimed that it is illegal for Canadians over 65 to get many operations. Not to be outdone, Democratic presidential hopeful, Paul Tsongas asserted last year that he could not have received his autologous bone marrow transplant in Canada in 1986. None of these assertions are true. However, the Canadian system does have its problems and a careful study of the Canadian system is essential for Americans to make wise choices about the future of their system.

This paper gives an example of the lies being told about Canada's system, compares the performance of the two systems, identifies the problems which the Canadian system faces, and then outlines some lessons Americans might draw from the Canadian example.

Lies about Canada

On Tuesday, February 20, 1990, Vancouver General Hospital's cardiac catheterization lab was even more hectic than usual. A crew from America's Public Broadcasting System (PBS) was busy filming Dr. Victor Huckell as he performed the ultimate diagnostic work-up for heart problems. Almost all of the patients seen that day were men with coronary heart disease (CHD), the most common cause of death in Canada, the United States, and most other developed countries.

The film crew was shooting scenes for *Borderline Medicine* -- a documentary comparing how similar patients are treated in the Canadian and U.S. health care systems. Mr. Albert Mueller was one of the patients filmed in that day's sequence.

Roger Weisberg, the show's producer is well known for his liberal views about America's social problems. Borderline Medicine was right up his alley. "The documentary tries to debunk some of the myths that are emerging about the Canadian system in the United States. On balance, the Canadian system comes off looking extremely attractive and puts our system to shame", Mr. Weisberg told Paul Taylor, Medical reporter for the Globe and Mail.[1] Unfortunately the segment about Mr. Mueller fed directly into American myths about Canada's health care system.

The documentary informed viewers that a few months prior to his catheterization, Mr. Mueller had developed angina -- chest pain caused by blockages in his coronary arteries. That day's test results confirmed he was in big trouble. Both major coronary arteries were completely obstructed. His heart was already showing signs of damage as a result.[2] Dr. Huckell told his patient his condition was very serious and that he needed surgery urgently.

Walter Cronkite was the show's narrator. The stature of this former CBS news anchor -- he's known as "the most trusted man in America" -- almost certainly added to the show's credibility. Towards the end of the program, Mr. Cronkite announced ominously: "Five months later, Albert Mueller is still waiting for surgery, despite the fact that 25% of patients with left main coronary artery disease die within a year."[3]

Unfortunately, this story completely misled its American audience. For Mr. Mueller didn't have to wait five months for his surgery. He could have had the operation almost right away. He just didn't want it. A year after the program was filmed, Dr. Huckell admitted that he knew Mr. Mueller's heart problem was urgent. He wanted to get him to a surgeon immediately.[4] But Mr. Mueller wasn't interested. The patient simply refused to have surgery or even see a surgeon to discuss it. As the months passed, Dr. Huckell advised his patient several times that he needed the surgery but Mr.Mueller remained adamant. About four months after his catheterization, the Vancouver General Hospital also contacted the patient twice and offered him the surgery.

Mr. Mueller refused both times. As far as he was concerned, the drugs he was taking for his angina were working. He was feeling better. So much better, in fact, that he spent the spring and summer of 1990 driving around the western United States and Canada, visiting relatives. But, Mr. Mueller's heart problems did grow worse and his condition deteriorated. He had surgery in February, 1992.

In fact, closer investigation of heart surgery waiting list stories reveals them to be either completely false or greatly misleading. In Ontario, in 1988 and 1989, the media reported on a number of deaths among patients waiting for heart surgery.[5] Doctors and hospitals pressured Ontario's Ministry of Health to increase funding for cardiac surgery.

Sometimes, Canadian doctors and hospitals engage in what University of British Columbia health economist Robert Evans calls 'orchestrated outrage'.[6] That is, they embellish or concoct circumstances which make it look like someone has suffered because of inadequate resources. In retrospect, Mr. Weisberg and his colleagues may have found themselves in the middle of an

example of this 'orchestrated outrage'. Dr. Charles Wright, the vice-president for medicine at the Vancouver General Hospital, says heart surgeons sometimes give the impression that waiting lists are more severe than they really are, because they want more facilities for what they do.[7] Dr David Naylor, the Director of the Institute of Clinical Evaluative Sciences at Sunnybrook Hospital in Toronto agrees that some surgeons play to the media. He says some doctors prefer to keep long waiting lists instead of referring patients to other surgeons with shorter lists "...on the grounds that the queues illustrate the inadequacy of government resources for cardiac surgery."[8]

In response to stories about heart surgery waiting lists, the Ontario Ministry of Health launched an investigation, appointing a panel of cardiologists, cardiac surgeons, and epidemiologists to study the issue and recommend solutions. What they found were several serious management problems that were much more central to the waiting list problem than a lack of resources.

For example, it was found that at the height of the perceived crisis in 1989, the Toronto General Hospital's department of surgery took away one and one-half days of operating-room time from cardiac surgery and gave the slots to general surgery. Had this not occurred, almost 10% more open-heart procedures could have been done in Metropolitan Toronto.[9] Was this a management problem or an example of 'orchestrated outrage' or was it simply an internal decision to focus more on general than cardiac surgery?

It also turned out that although some surgeons and some hospitals had long waiting lists, others didn't.[8,10,11] The investigation showed that some surgeons with long lists didn't use a formal system for priorizing patients. Other surgeons, sometimes even in the same hospital, had lots of openings. The expert panel recommended a number of specific changes in the management of heart patients and called for a modest increase in resources. Their recommendations were soon implemented.

By 1990, a new triage system and a registry were in place to priorize patients and route them to other surgeons or hospitals if their doctor couldn't perform the operation within an appropriate time interval.[12] The Ontario government also added 10 percent to the resource base for cardiac surgery. Together these measures went a long way towards solving the problem of waiting lists.

On August 11, 1992, Canadian media mogul Ted Rogers had bypass surgery at the Mayo Clinic. His doctor in the Bahamas made the diagnosis and recommended his patient have his operation in the U.S. But there was no need by then for anyone from Ontario to go south for heart surgery. According to Dr. Tirone David, chief of cardiac surgery at the Toronto Hospital, his patients' waiting times were now down to two weeks, at the most.[13]

US opponents of public health insurance have also played on the general ignorance about the urgent nature of bypass surgery. The public tends to believe that once CABS is recommended it is necessary immediately or the patient is at great vital risk. In fact, only patients with left main coronary artery obstruction or multi-vessel disease with very unstable angina have more than a 0.33% death rate per month on a waiting list.[14] Many patients face no vital risk while waiting although they may suffer physically, psychologically, and economically.[15,16] High risk patients are typically only 15 to 20% of any centre's total patients.[17,18]

Gradually the other provinces have been going through the same process as Ontario. First, headlines claiming deaths on waiting lists. Initially a panic response and then better management measures to solve the problem. The heart surgery waiting list story highlights some of the real issues affecting Canada's health care system.

1. Many well-hyped horror stories about Canada's health care system are frankly untrue and are sometimes concocted or pushed by providers as part of a campaign of 'orchestrated outrage'.

2. Canada's health care system is very responsive to political pressure. The Ontario Ministry of Health rather quickly developed policies in conjunction with the medical profession which markedly reduced waiting times.

3. The problem was remedied with very few additional resources. This reinforces the general point that most of Canada's problems are due to lack of management rather than lack of resources. Canada's system is not government run. It is government funded but it is mainly managed by private interests -- doctors and hospitals.

The costs of the two systems

There are many different methods of comparing the costs of two countries' health care systems.[19] However, if one is interested in relative cost-control for health care amongst different countries the best method of comparison is the proportion of the economy devoted to health care (eg. gross domestic product or GDP). The proportion of GDP also allows comparisons to be made both at a point in time and over time.[20] It is important to remember that this statistic is a ratio and an increased proportion of GDP devoted to health care could reflect either increasing health care costs or poor GDP growth or both.

In 1971, when Canada had fully implemented national health insurance both the US and Canada spent approximately 7% of their GDPs on health care. By 1991, Canada spent 9.9% of GDP on health care while the US spent 13.2%.[2]

Most of this difference is due to lower costs of administration, lower payments to physicians, and lower hospital costs.[21] Administrative savings are mainly due to the efficiencies from the economies of scale of Canada's large provincial health insurance plans.[22] Hospital expenditures are higher in the US primarily because of the higher intensity of servicing of hospitalized patients.[23] However, there may be little, if any, benefits from this increased servicing.[24]

Eligibility and Access to Care

All Canadians are eligible for health insurance as a right of citizenship. In fact, landed immigrants, established refugees, and foreigners claiming refugee status are also eligible for health insurance. Two provinces (Alberta and British Columbia) and one territory (The Yukon) charge their residents health insurance premiums although payment of premiums is not required to be eligible for insurance coverage. There have been anecdotal reports of persons being denied care in these provinces if they have not paid their premiums.[25,26]

The Canada Health Act passed by the Canadian Parliament in 1984 outlines the criteria which must be met by provincial health insurance plans to be eligible for federal government assistance. One of the criteria, comprehensiveness, requires the provinces to insure all 'medically necessary' care provided by physicians. There is considerable variation in the other services provided but most provinces provide some coverage for prescription drugs, durable medical equipment and long-term care (both institutional and community).

Almost all Canadians live within 30 miles of a hospital. There are large numbers of physicians in urban areas and the south of the country within 100 miles of the American border. Physicians do locate their practices within poor urban neighbourhoods, contrary to the US situation. There are problems attracting physicians to northern and rural areas of the country.[27,28] There is some evidence that rural residents in southern Canada consume the same number of physicians services although they may have to travel to receive them.[29] Canadians in rural and remote settings also have less accessibility to non-medical services such as psychology and rehabilitation. Primary care nursing services are available in almost all remote communities.

Canadians may visit any doctor they wish at any time when they can arrange an appointment. Provincial health insurance plans only pay specialists at general practitioner rates if there is no GP referral. However, specialists will often extract the name of a GP from the patient and add that doctor's health insurance billing number to the insurance claim to ensure payment at the higher rate. In most communities doctors focus care through family physicians but in others internists, gynecologists, and pediatricians provide significant amounts of primary care.

Access and Utilization of high-technology specialized services

The most serious American criticisms of the Canadian health care system focus on access to high technology care, such as heart surgery. Typically, provincial governments must provide specific approvals for expensive high-technology services such as open-heart surgery, transplantation, and magnetic resonance imaging (MRI). There are limitations to the data in making these comparisons. However, the overall conclusions of the existing data are:

1. Canadians do have lower utilization of high capital, high-technology services, especially open-heart surgery, CAT scanners, and MRI scanners.

2. Low income Canadians have better access to high technology services than uninsured or poorly insured Americans.

3. Canadians, on average, have similar access to high-technology services for emergent and urgent conditions as well-insured Americans.

4. Canadians, on average, have less access to high-technology services for elective and non-urgent conditions than well-insured Americans.

The United States has over 2000 MRI scanners while, as of October, 1992, Canada had only 22.[10] However, when there are many scanners with most operating at below peak capacity, the price per unit of service is increased. Also, uninsured and poorly insured Americans, representing perhaps 25% of the population, have little or no access to MRI.[12]

In 1987, the overall US rate for coronary artery bypass surgery (CABS) was 95 per 100,000[11], while the Canadian rate for 1988-89 fiscal was approximately 55.[32] The US rate for those under 65 is only about 30% higher than in Canada while the rate is 50 to 75% higher for the elderly. Far from these data indicating a lack of heart surgery for older Canadians, they may indicate too much surgery for older Americans. And, there is evidence that many younger Americans don't get heart surgery they do need because of costs.

Dr. Geoffrey Anderson of Toronto's Institute for Clinical Evaluative Sciences[33] has found that poor Canadians are most likely to get heart bypass surgery while poor Americans are the least likely to get the operation. Other investigators have also found that wealthy Americans are more likely to get heart surgery than poorer Americans.[34,35] Given that heart disease death rates are four to eight times higher for the poor compared to the rich, it is a safe conclusion that there are many poor Americans who have a medical need for surgery but don't get it.[36] And, wealthy Americans might be getting too much heart surgery. Dr. Anderson cautions that we can't necessarily draw this conclusion from his study but he adds, "We can say that in the United States the financial incentives for hospitals to perform surgery are quite attractive, and maybe they do too much."[37]

Another, illustration of American vested interests' misleading rhetoric on high tech health services is the focus on the number of 'units' as opposed to the number of procedures. For example, the National Centre for Policy Analysis has recently claimed that the US has three times as many heart surgery units per capita as Canada.[38] However the actual number of heart operations performed is only about 50 to 70% greater. In Canada, almost all heart surgery is

done in University hospitals -- and these centres handle large volumes of cases. In the US many community hospitals have fledgling heart units which perform small numbers of operations. These hospitals don't establish their heart units to meet community needs but rather to more effectively compete with other hospitals in the district.

In Canada, concentrating services maintains the skill level of surgical teams -- which provides an added measure of safety for Canadian heart patients. Studies in the US have shown that heart surgery death rates are much higher in hospitals with low surgical volumes.[39] And, as mentioned above, if a community has more heart units or MRI scanners than it needs then they run at low capacity which increases the costs per unit of service. Therefore, the higher number of heart units in the US is actually a sign of poor quality and resource waste -- hardly a point of pride!

Access and Utilization of non-high technology services

Canadians consume more hospital and physicians services than do Americans. In 1989, Americans used 814 hospital days per 1000[40] while the comparable figure was 1164 days per 1000 in Ontario, Canada's largest province.[41] In 1987, Canadians used 50% more physicians' services than Americans.[42] In 1987, residents of Ontario had a rate of major surgery* 35% higher than California and 15% higher than New York State.[43]

Canadians have much better access to primary care services. In 1988, 52.5% of Canadian physicians were general or family practitioners whereas in the US only 13.3% of physicians were in these categories.[44]

Most hospitals are non-profit private corporations. Some boards are elected by general suffrage from local government area but most hospital corporations have limited membership with self-replicating boards. The provincial ministries of health make almost no decisions about which services are offered by hospitals. There is little government oversight of hospital operations. In fact, the hospital branch of the Ontario ministry of health has only 80 non-clerical staff to manage a budget of over $8 billion (CAN). In 1991, the Toronto General Hospital told the Ontario provincial auditor that it could not look at the records of a $3.2 million expenditure.[45] Two years later, the details of that expenditure remain unexamined by a public authority.

Provinces fund their hospitals with global budgets. Some provinces are now using a modification of the DRG system to calculate a portion of the budget but, by and large, the budgets have been increased over time across the board with little adjustment for volume or case mix. The result is a situation where some communities are relatively richly endowed with resources compared to others. However, there is little hard data of the scope of the problem and the same situation pertains in other countries with as widely disparate funding mechanisms as the US[46] and the United Kingdom.[47]

The decisions about resource allocation within hospitals are determined mainly by the physician group. For example, the chief of surgery is typically responsible for the allocation of operating room time. On closer examination many complaints about lack of funding for certain specialty services are really a cry for public assistance when the specialist has lost the internal hospital debate. Recently, with increased budgetary pressures, hospital administrators have been playing

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* Defined as a procedure which was not performed on a not-for-admission basis in 1987.

a more active role. With the development of better systems for determining actual patient costs, administrators have targeted high cost services such as orthopedics and neurosurgery for cuts. Certain high-cost services such as transplantation, cardiac surgery, and diagnostic imaging require specific ministry of health approval. However, doctors and administrators have some discretion in these areas as well.

Medical practice

Most Canadian physicians are in private practice and are paid on a fee-for-service basis. Most provinces have instituted electronic billing and most doctors are paid within 2 to 4 weeks of claim submission. In Ontario in fiscal 1992-93, 96.5% of claims were paid within four weeks of submission.[48] In Ontario from 1982 to 1992, an average of 0.2% of doctors per year were asked to repay moneys which had been paid by the province's health insurance plan.[49] There are no user charges allowed for basic medical and hospital care. Doctors can bill workers' compensation agencies for care of work-related injuries and illnesses and, are allowed to bill patients directly for services not covered by the plan (eg. insurance forms, cosmetic plastic surgery).

Multi-specialty group practice is very uncommon. There are about 250 community health centres (CHCs) where doctors are paid salaries and there are other primary care professionals (nurses, social workers). 170 of these are in Quebec where they are called CLSCs (Centre Local Services Communitaire. Quebec has given CLSCs a clear mandate to provide general primary care as well as home care and children's mental health. CLSCs have community boards are given discretion to identify three priority areas to meet their own local community needs. Quebec now devotes over 5% of its overall health budget to the CLSCs.

Ontario has almost 50 CHCs and the province is committed to expanding the program by 3 centres per year. Ontario's CHCs are largely designed to alleviate non-financial barriers to access for specific groups (eg. the poor, frail elderly, immigrant communities, francophone minorities).

Ontario has also established 90 health service organizations (HSOs) which receive capitation payments for ambulatory care. There are three community governed HSOs and two with University affiliation while the balance are owned by family doctors. Most are small (3000 to 6000 patients) but the Sault Ste Marie Group Health Association clinic is governed by a community board and has over 30,000 patients. The program was frozen three years ago because of provincial concerns about lack of accountability. The ministry is currently negotiating program changes with the Ontario Medical Association (for the private HSOs) and individual non-profit HSOs.

Ontario has also initiated the comprehensive health organization (CHO) program. The CHO will receive provincial capitation payments for ambulatory and acute hospital care. It might potentially incorporate funding for long-term care and prescription drugs. CHOs will be governed by non-profit community boards. On paper the funding looks remarkably similar to a US health maintenance organization (HMO). However, the ministry has only funded one CHO so far and it is located in a remote community.* It will likely function as a quasi-governmental regional health authority.

Health status

General social and economic conditions have much more impact than health care on conventional measures of health status such as life expectancy and infant mortality. However, if Canada's health care system was as inadequate as some American critics have suggested, these should be reflected in poorer health status for Canadians. In fact, Canadians enjoy better health status than Americans. (see table one)

In recent years the US record for low birthweight has actually been getting worse while Canada's has continued to improve.[50] Low birthweight is the major predictor of infant mortality and is

effected in minor fashion by traditional pre-natal care. One recent study has suggested that 60% of the difference in infant mortality rates between Canada and the US is due to the higher rate of low birthweight in the United States.[51]

However, there are numerous examples of where US patients' health status has been adversely affected by financial barriers to care. Recent studies have documented decreased access and poorer outcomes according to financial situation and/or insurance status for newborns[52], glaucoma[53,54], childhood immunization[55], and mammography and pap smears.[56] One study showed that the uninsured were more likely to die after hospital admission.[57]

Problems with Canada's health care system

Canada's health care system faces a similar set of problems as do the health care systems of other industrialized countries including the US. However, the US has, by far, the most serious problems with costs and access. The major problems identified with Canada's system by a series of recent government reports include:

1. Too much focus on curative medicine as opposed to health promotion and disease prevention.

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* The CHO is to be located in Fort Francis which is a pulp and paper town of 9,000 near the Minnesota border.

2. Inefficiencies due to the organization and financing of the system. For example, Canadians overuse institutional services compared with community services. Also, the predominant method of physician payment is fee-for-service.

3. Inadequate quality assurance leading to the provision of inappropriate care. There are few explicit written standards. There is little monitoring of physicians, even by other doctors.

It is important for Americans to realize that these problems are specific to the model of single-payer plan implemented by Canada. None of these problems are related to public health insurance. Rather, they are related to relatively unaccountable private management of the system by doctors and hospitals.

Other effects of public health insurance

In Canada, management and labour do not negotiate basic health benefits. They do negotiate for so-called extended health benefits such as dental care and prescription drugs. However, in the United States, negotiations about basic health benefits have become increasingly acrimonious. In 1990, health care was the major issue in 83% of negotiations and 55% of strikes and lockouts.[58]

Also, the US system of health insurance increases costs to business. Chrysler has estimated that it cost $700 (1988 US dollars) in health benefits for each car it produced in the US but only $233 for the cars it produced in Canada. This evidence led Ontario Premier Bob Rae to comment,

"The cost advantage for us in manufacturing in terms of the health care issue is enormous and it's growing. The longer the Americans take to resolve this, the happier I'll be."[59]

A consistent theme of various government health reports of the past two decades has been that health care is not nearly as important for the population's health as social and economic factors. Other countries spend less of their economy on health care than the US but spend more on other

areas of social policy.[60] This is reflected in the high rates of officially designated poverty in the US compared to other industrialized nations. There is little discussion within the United States of the opportunity costs of the world's most expensive health care system. However, the massive resources allocated to the treatment of illness clearly preclude investments in other social programs which would more efficiently promote health.

Lessons for Americans from Canadian Public Health Insurance

The main lessons for Americans from Canada's health care system are as follows:

1. The cost savings from a single-payer plan are real. Canada's system is more than 3% of Gross Domestic Product less costly than the American system. The savings are due to factors associated with a single-payer plan, including lower administrative costs and reduced hospital and physicians costs.

2. Canadians have better access to almost all health services than do Americans. Canadians use more physicians' services and hospital services than do Americans.

3. Canadians, on average, have less access to high-technology services than do well-insured Americans. However, it appears the health impact of this decreased access is minimal, and so far, anecdotal. Furthermore, uninsured or poorly insured Americans, representing perhaps one-third of all Americans, have less access to high-technology services than do Canadians. There is considerable documentation of the adverse impact on the uninsured and poorly insured in the US.

4. The major problems of Canada's health care system have little or nothing to do with single-payer financing. The problems relate to the method of organization and financing of the largely private delivery system. The US could implement its own national health program and avoid Canada's difficulties.

Table one. Recent health status indicators in Canada and the United States

	Canada	United States
Infant mortality	0.68% 1990[61]	0.91% 1990[61]
Low birthweight (< 2500 grams)	5.1% 1989[62]	7.05% 1989[62]
Very low birthweight (< 1500 grams)	0.84% 1989[63]	1.28% 1989[63]
Life expectancy at birth		
Male	73.4 years 1988[64]	71.5 years 1988[64]
Female	80.3 years 1988[65]	78.3 years 1988[65]
Life expectancy at 65 years		
Male	15.0 years 1988[66]	14.9 years 1988[66]
Female	19.6 years 1988[67]	18.6 years 1988[67]

Endnotes:

1. The Toronto Star, November 9, 1990.

2. Dr. Huckell states that Mr. Mueller had a complete obstruction of his left main coronary artery and his right coronary artery.

3. In fact that figure should have been closer to 10% to 15%. See: Takaro T, Pifarre R, Fish R. Left main coronary artery disease. Progress in Cardiovascular Diseases. 1985;28:229-234.

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Statement of
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My name is Eugene Feingold. I am a Professor Emeritus at The University of Michigan School of Public Health, where for almost thirty years I did research and taught about the organization and administration of medical care programs.

I am submitting this testimony on behalf of the American Public Health Association, of which I am President-Elect. The American

Public Health Association is the largest organization of public health workers in the United States. Together with its affiliated state associations, it represents over fifty thousand people who work in or teach about our public health system. We are pleased to have the opportunity to submit testimony to your subcommittee today.

The health care crisis:

A 1991 Gallup Poll found that 91% of its respondents felt that the United States health care system was in crisis. This attitude has been widely expressed not only by the general public, but also by scholars and practitioners who work with and in the system. The elements of this crisis in our medical care delivery and financing system are, briefly, cost, access, and quality. The problems in these areas are widely recognized, and I will therefore only briefly describe them.

The problem most often cited is high cost, increasing rapidly, with the resulting burden on individuals, businesses and governments. The complexity of our system of paying for medical care contributes substantially to this cost. The United States is a rich country, and we might be able to afford this expenditure. However, we are not getting good value for the money we spend, nor have we had the opportunity to decide that we wish to spend our money in this way, rather than for other community needs.

The second element in the medical care crisis is access. More than 37 million people are without any public or private insurance for the costs of medical care. That, however, is a one-time snapshot -- the number of people without coverage at this point in time. However, people gain and lose insurance over time. The Census Bureau has estimated that 63 million people were uninsured at some time during a recent 28-month period. And the number of persons without any coverage has been increasing steadily.

In addition to those completely without coverage, there are many with inadequate coverage. Just the other day, I received a

promotional mailing for health insurance that paid the munificent sum of $10 a day for every single day I spent in the hospital. Someone who purchased that insurance would be counted as insured -- but surely not adequately insured. The inadequately insured have been estimated at twenty to seventy million, depending on how one defines adequacy.

Our system of health insurance is largely employment-based. But, because of the high and rapidly increasing costs of medical care, employers are backing away from providing insurance, or cutting back on the insurance they are providing. These employer efforts have played an important part in almost every major labor dispute in recent years.

Now, we have the final straw -- the H. & H. Music Company. When an H. & H. employee became ill with AIDS, the company retroactively changed its health insurance plan to provide only $5000 in lifetime benefits for AIDS. The U.S. Court of Appeals said this was permissible, and the U.S. Supreme Court refused to review the case last November. Because H. & H. was self-insured, ERISA gave priority to the financial stability of the plan over meeting its health insurance obligations.

That means that any employer that wants to self-insure -- and most major employers are already self-insured -- can retroactively eliminate or cut back on its health insurance benefits whenever it wants to. So what we have is no longer insurance -- rather it's UNsurance -- you get sick, they don't pay.

The result of all this is that people are anxious: They're afraid to change jobs because the new employer's insurer might not cover them for pre-existing conditions. They're afraid that if they lose their jobs, they'll lose their health insurance -- and many people, even middle class people, have been losing their jobs. They're afraid that even if they keep their jobs, they'll lose their health insurance.

But the impediments to access are not merely financial. Inner cities and rural and frontier areas all suffer from a lack of health care personnel and facilities. Studies have shown that race and sex are also barriers to appropriate care independent of financial factors.

The third aspect of the medical care crisis is quality and appropriateness. We have inadequate numbers of primary care practitioners, leading to fragmented care in which an individual may be treated by a number of specialists without ever being looked at as a whole person. We have excess numbers of hospital beds and specialists, driving up costs and simultaneously lowering quality

because many of those practitioners don't do procedures often enough to maintain their skills.

Studies conducted by the Rand Corporation have concluded that a large number of medical procedures are unwarranted. At the same time, rural and frontier areas have inadequate services. As a result of all this, we fall short of much of the industrial world in areas where health care is important. As is usually the case, all of this is much worse for minorities and the poor.

However, all this describes only the crisis in medical care delivery and financing. We have a crisis in public health as well. Americans were beginning to think that infectious disease was something they didn't have to worry about. We now have AIDS, sexually transmitted diseases, and a resurgence of tuberculosis, now often drug-resistant. We have problems of teenage pregnancy, of homelessness. Violence pervades our society: child abuse, domestic violence, and homicides are all increasing. We face spreading health problems stemming from poverty and poor education, environmental neglect, risky behavior, and lack of access to preventive care. The "Index of Social Health," published earlier this week by Fordham University, stands at its lowest level since it was first prepared in 1970. And again, the poor and ethnic minorities have the worst of it.

At the same time that our problems are increasing, many -- if not most -- states, faced with serious financial problems, have been cutting back their support for public health activities and laying off public health workers.

S. 491, The American Health Security Act:

S. 491, introduced by Senator Wellstone, and its companion House bill H.R. 1200, introduced by Representatives McDermott and Conyers, provides an effective attack on the problems comprising the medical care and the public health crises. The American Public Health Association strongly supports these bills.

S. 491, by establishing a single-payer system, would simplify the administration of medical care financing, saving as much as $100 billion a year. Equally important in restraining health care cost increases are S. 491's global institutional budgets, rate-setting, and controls on drug and medical equipment prices. The system would be financed through progressive taxation, the fairest and most equitable way.

S. 491 would deal with the access and quality problems I have described by providing universal access to comprehensive medical care benefits. It would reshape the health care delivery system to emphasize primary care, and would expand services to medically underserved rural and inner city areas. It would expand the use of outcomes research and practice guidelines, and encourage multidisciplinary training.

Finally, S. 491 goes beyond the medical care crisis to address the public health crisis. The American Public Health Association recognizes that S. 491 was one of the first health care reform bills to recognize the importance of enhancing and strengthening the public health system, and compliments its sponsors for their efforts in this direction.

President Clinton's proposal:

Many of the public health and primary care elements so important in S. 491, as well as the title "American Health Security Act," also appear in the draft proposal put forth by President Clinton on September 7, 1993. President Clinton's proposal for dealing with the crisis in medical care financing, however, is based on a different concept, that of managed competition. There are different forms of managed competition, but the basic idea underlying managed competition is that, because of health insurance, the consumer has no incentive to be concerned about the cost of medical care.

Once he or she has paid the premium, or it has been paid by his or her employer, the cost to the consumer remains the same regardless of how much medical care is used, regardless of whether the consumer goes to an extravagant wasteful physician or one who provides more cost-effective care.

Providers also are discouraged from being economical. Physicians are usually paid on a fee-for-service basis, which means the more services they provide, the more they earn. Hospitals have traditionally been paid on a cost basis, which again rewards them for generating more costs.

Moreover, the argument goes, this lack of concern about costs is encouraged by the tax treatment of health insurance. Employers are permitted to deduct health insurance premiums as a cost of doing business, so they have only limited incentive to keep those premiums low. Employees have no incentive to choose less expensive health insurance because they pay no income taxes on health insurance premiums that are paid on their behalf by their employers.

Managed competition would deal with this problem of incentives by making consumers and employers more conscious of health care costs. Insurance and prepayment plans, responding to that concern, would try to compete with each other on the basis of price. In order to do that, they would force providers to deliver more cost-effective care.

The idea, then, is a kind of domino effect -- consumers pressure insurers, who in turn pressure providers. The basic concept of managed competition is one of cost-conscious consumer choice among competing private plans. It's based on the assumption that consumers will be able to fend for themselves in the market and force providers to compete with each other on price and quality. President Clinton's version of managed competition has backed away from pure reliance on the market, and provides some regulation to avoid the deleterious effects of pure market reliance. His modifications, however, are not adequate to protect consumers, restrain costs, and protect the public's health.

Managed competition is based on theoretical assumptions that are often questionable. First, there's the underlying idea that consumers get more medical care than they need or want because they're insured and can therefore ignore the costs. This assumes that all, or at least a very substantial group, of the population has insurance coverage which pays all or almost all costs. We know that isn't true. Thus, the idea that most people are insensitive to health care costs is at best an oversimplification.

Second, even if insurance is the problem, the focus on the consumer is inadequate or unfair. The evidence is that most medical care cost increases stem from intensity (the number of services provided) and the use of high technology. The decisions to use those services and that technology is made by physicians or other providers, not by consumers. The decision made by the consumer is simply to visit his or her physician, not what the physician will do once the visit takes place. But it's the office visit which has the least insurance coverage. Thus, the most meaningful target is the provider, not the consumer.

Third, managed competition theorists seem to imply that people buy health insurance simply or primarily because it's tax-free. It's clearly true that some consumers think about the non-taxable nature of health insurance and make the decision that they would

rather have their employer pay for their health insurance than pay them in cash. However, even those people are not interested in health insurance just because it's tax-free. They want health insurance because it does something for them -- it protects them against unpredictable costs.

All the evidence we have is that people buy as much health insurance as they can afford because that protection against uncertainty is very important to them. They want to be covered so that they don't have to make the kind of rational trade-offs between cost and care that the competition analysts would like them to make. If that's true, then modifying the tax status of health insurance will only discourage the purchase of health insurance by low income persons -- precisely those who need it the most.

Fourth, managed competition assumes that insurers or providers will put together competing plans: make consumers cost-conscious and a system of plans that will compete with each other will spring up. But, even if this does happen in large urban areas, what about

the many areas of the country that have only one hospital, or only a few physicians? A substantial part of the U. S. population lives in regions with population densities too low to support competing plans.

Fifth, assuming that those competitive plans are put together, will the insurers really pressure the providers to keep costs down? Past history on this isn't too encouraging. Although there has been some pressure on providers, insurers have more frequently tried to reduce costs by selecting the consumers they would cover. Moreover, in specialties or geographic areas where providers are limited in number, insurers will not be in a position to pressure them.

Sixth, managed competition assumes that the consumer will have sufficient information to make intelligent choices between plans. Again, our past history is not encouraging -- consumer information has been largely limited to price, and not very clear information

about price at that. Medical care isn't a single product, but a complex mixture of products. It's very difficult to provide the kind of information that consumers would need to make meaningful choices in an area as complex as medical care.

Seventh, cost-sharing, i. e., deductibles and co-payments, is usually included in managed competition plans as a way of increasing cost-consciousness. The argument is that it discourages consumers from seeking unnecessary services. However, we know that it discourages both necessary and unnecessary services. We know that it discourages prevention and early treatment. We know that it encourages crisis-oriented secondary and tertiary services, which are precisely the most expensive services. Finally, we know that it has a heavier impact on the low income population, precisely those with the highest medical care needs.

Managed competition variations which offer substantially different benefit packages pose the additional danger of creating a multi-tier medical care system, with lower-income persons provided with poorer benefits. President Clinton's proposal does not do this, and so I'll not discuss those problems further.

APHA prefers a single-payer approach:

For all these reasons, APHA continues to favor a single-payer solution to our medical care financing problems -- it's simpler, more likely to control costs, and likely to be more equitably financed than President Clinton's managed care proposal.

Promoting and maintaining the public's health, however, requires much more than the reform of medical care financing. The American Public Health Association is therefore particularly supportive of the community-based public health services that are supported by S. 491. Beyond these services stands the need to deal with the causes and results of poverty, probably the most important cause of ill health in the United States.

History of Medicine

The Role of Saskatchewan in Government-Sponsored Health Care: A Retrospective View

*Senator E.W. Barootes MD, FRCSC**

Doughty Tommy Douglas

No one person has had as profound an effect on the restructuring of health services in Canada as Tommy Douglas, that doughty little Scottish socialist fighter and orator who was premier of Saskatchewan from 1944 to 1961. It should have surprised no one when he announced, on December 17, 1959, that he would introduce a medical care program for the province, because he had professed dedication to that goal throughout his political career.

His plan was to be universal, comprehensive in benefits, financed with premiums, publicly administered, and acceptable to those receiving and those rendering service. The details were to be recommended by an appointed advisory committee of 10 persons, including three appointees from the College of Physicians and Surgeons of Saskatchewan, which then also included the Saskatchewan Medical Association. His announcement was criticized by his opponents and by the medical profession as political expediency because it was made shortly before an expected provincial election. But successful politics involves opportunity and timing. The opportunity was created by the Diefenbaker government that year when they undertook to cost-share provincial hospitalization plans, yielding a $12 million windfall to Saskatchewan's treasury. As for the timing, it was politically superb.

Douglas won the election in early 1960 with an increase in Co-operative Commonwealth Federation (CCF) members, although his popular vote, in a four-party contest, plunged below 41 per cent. But he did this despite the fact that, for the first time, the provincial medical association engaged in the election campaign through an ill-disguised, well financed Public Medical Information Bureau. The association even had the audacity to debate the formidable Douglas before a live television audience, in a format now fashionable in elections.

A Leader in Health Care

Saskatchewan has been the crucible for pioneering health care programs in North America since 1916, when Municipal Doctor Programs used taxes to attract and pay for a local doctor. In the early 1920s, citizens and doctors united in the unique Anti-Tuberculosis League by providing free comprehensive care to sufferers in sanatoria. They pioneered in tuberculin testing, bacille Calmette Guérin (BCG) vaccination, and mobile chest X-ray vans. They also pioneered in mandatory chest films on hospital admissions, a program that was emulated elsewhere. By the mid-1930s, the medical association had persuaded the Conservative administration to introduce the Cancer Clinics. Saskatchewan can point to the world's first cobalt-60 beam unit and first betatron unit, and to biophysicists Dr. Harold Johns and Dr. Sylvia Fedoruk, who is now the Lieutenant-Governor.

In 1942, the Saskatchewan Medical Association, mindful of the tragedies of the Depression, resolved to support state-aided health insurance. In 1945, Saskatchewan established North America's first free health care service for indigents, the disabled and elderly; the cost virtually equally shared by the CCF government and the profession. Acceptable initiatives by Premier Douglas, who was also Minister of Health, followed: in 1947 North America's first universal hospitalization scheme; the next year, after a local plebiscite, North America's first compulsory and comprehensive medical care program, a pilot project for 50,000 residents in the Swift Current health care region, which had been ravaged by drought in the 1930s and depleted of doctors during the war.

To replenish our depleted doctor population, reciprocal licensing with Great Britain was legislated. To ensure that new doctors would establish where they were needed, small hospitals were built in rural areas. To compensate for primitive roads, an air ambulance service was started, using the deserted air-strips of the Commonwealth air training scheme. Meanwhile, voluntary non-profit medical care insurance programs provided protection for individuals, groups, and municipalities.

Why then, with such co-operation, should there have been turmoil after Douglas announced his intentions?

Opposition Mounts

To introduce a health care program smoothly, two ingredients are required: need and trust. First there should be a publicly recognized need that leads to public acceptance. The programs recited were born of social and economic necessity. The second requirement for success is mutual trust between those administering a program and those providing the service. From 1960 to 1962, doubt arose about both need and trust. The government ignored a plebiscite of 1956 that was to extend the Swift Current plan to two more health regions of 130,000 people. It was rejected by three or four to one. And trust eroded because Douglas not only failed to consult the profession first, as he had promised, but also because his five stated principles, plus a short time-frame for the advisory committee pre-determined and proscribed their decisions.

Public skepticism, cultivated by the profession, grew and gave more impetus to the opponents of "state medicine" and to political adversaries of the government. General acceptability and trust broke down, and a dispute with political overtones took over. Vigilant media brought the issues to the public. Pressure from a group of affected professionals developed into an uncontrollable community conflict.

Each party gave the other cause for suspicion from the start. The government must have become wary in October 1959 when the college renounced its request for state-aided health insurance, resolving instead to oppose any "compulsory, government-con-

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trolled, province-wide" plan and supporting "extension of health benefits through the voluntary service plans," which they controlled. The doctors complained about the composition of the advisory committee, which included two civil servants and the previous minister of health. The medical association delayed appointing their three members until the terms of reference were widened to include all health needs, and the arbitrary time limit was removed.

The profession felt threatened. Doctors feared loss of professional independence, interference in medical decision-making, erosion of the confidential patient-doctor relationship, and conscription to civil-service status. They preferred freedom of choice to compulsion, and predicted the rising costs of a "free" service would lead to funding constraints and deterioration in the quality of care. They were upset that the promised pre-consultation was denied them, although they had publicly proclaimed their opposition, and would have their views presented at the advisory committee along with other interested groups.

Mounting Tension

The advisory committee started its studies in May 1960, after the election. By June 1961, the government, sensing that the three college representatives were diverting the focus from the medicare plan to other health deficiencies, such as hospital care, mental care, elder care, care of the disabled and rehabilitation, requested an interim report based on the medicare aspect alone. This reinforced the profession's paranoia of political motivation, especially since it was apparent that Premier Douglas was leaving to lead the new federal labor-dominated party being formed in Ottawa in July. It was desirable for him to bring the medicare act with him, no one in Canada being more deserving to do so.

The interim report was delivered on September 18, putting a time-lock on the legislation, because the premier announced November 7 as his resignation date. A majority of seven recommended a compulsory, comprehensive program, premiums, a public commission for administration, fee-for-service payment, and utilization fees. Four members, including the three college representatives, stuck to a universally available scheme through existing plans, with government aid to pay the premiums of the needy. The labor union representative, Walter Shmishek, also dissented, recommending a compulsory, comprehensive plan, paid for by income tax, administered by the department of health, and a salaried profession. A decade or so later, he became our minister of health. The compromise in the majority report was the fee-for-service principle in exchange for universality. It did not help the strained situation when this highly guarded report was leaked and reported in the Toronto Daily Star four days before its intended release, and one day after an exclusive interview with Premier Douglas. It added to the mistrust and diminished the sense of altruistic motives of the government.

A Bitter Battle

A medicare bill was drafted and the legislature was quickly summoned in October, without referring either the interim report or the bill to the college for comment, as was the custom, probably because of time constraints. This oversight later led to the resignation of the Minister of Health who steered the bill through the legislature, citing Douglas' repeated breaches of faith with the profession as a cause for quitting the CCF party.

That fall, the doctors found a legal avenue of escape. They could ignore the act, practise privately, and help patients to obtain reimbursement from the commission. The government delayed the starting date from January 1, 1962 to April and ultimately to July 1, 1962. Meetings between the cabinet and the college council in March and April failed to resolve their differences. On the last day, perhaps frustrated by the intransigence of the doctors, the government moved to block physicians from ignoring the act by so called "agency clauses," whereby a citizen seeking a doctor's services automatically made the medical care commission his or her appointed agent with that physician. This action was interpreted as a state seizure of citizens' civil rights. Even the closest advisors of the administration thought that this was done "unwisely, angrily and against best advice."

This unexpected development had profound effects in the province. For the doctors, meeting in a special convention on May 2, and hearing from Premier Lloyd and their legal advisors, it meant that, unless the act was repealed or changed, they must concede to work under medicare or leave their province. Many threatened to leave. Despite many changes favorable to the profession, almost 40 per cent of the registered doctors of December 31, 1961 deserted the province within 15 months of the start of the medicare plan. Patients and citizens formed "keep our doctor" (KOD) groups in many communities. It galvanized opponents of the scheme into an organization that ultimately helped defeat the government in 1964. This strategic blunder also led to the provincial media almost unanimously supporting the doctors' position, as citizens, media, and physicians echoed the Douglas promise of a plan "acceptable to those rendering and those receiving the service." This media support was in contradistinction to the attitude of outside media who invaded the province on the withdrawal of office services on July 1. What began as a third-party grievance by a professional group had become a community conflict that precluded rational or amicably negotiated settlement.

The doctors prepared to close their offices on July 1 unless the act was withdrawn or its implementation postponed. When Douglas was defeated in Regina in the federal election of June 12, wind was blown into the sails of KOD and the college, which now thought a plebiscite would easily defeat medicare. As the deadline approached, each side stubbornly held their position. Last-minute efforts by influential institutions failed. Premier Lloyd made reasonable last-minute concessions to avoid the crisis, but trust was now gone.

I believe, as did others, that if these concessions had been made three months earlier, before the agency clauses were introduced, when mutual respect and trust still existed, the situation could have been saved. Woodrow Lloyd, who was a decent person and a good friend, vacillated too long, buffeted by the doves and hawks of his cabinet and hard-pressed by the pleas of the federal New Democratic Party (NDP) power brokers. Had the charismatic Douglas stayed as premier, he would have made pragmatic changes to avoid open conflict and to establish his program of universal coverage. The government stood by its principles, however, and the doctors closed their offices on July 1 in protest.

The Doctors' "Strike"

About 30 doctors began practice under the act. Some 225 others staffed emergency hospital centres in rotation, working without pay, rather than accepting payment from the commission. A further 110 doctors were recruited by the government, mainly from Great Britain, under short-term contracts. Some have stayed in the province. The so-called "strike" lasted 23 days. Public feelings were becoming explosive, and our province was teetering on the edge of anarchy. Our president, Dr. Dalgleish, addressed the CCF convention offering to abide by the decision of plebiscite, but got "no" for a response.

Finally, reason prevailed and through the good counsel of Dr. Kelly and Lord Stephen Taylor, Dalgleish indicated willingness to resume normal practice if certain amendments were made. These had been mutually negotiated through the mediation of Lord Taylor, in a form called the Saskatoon agreement. Lord Taylor was a labor peer and physician engaged by the government to advise Premier Lloyd. Experts and legislators drafted the amendments to both parties' satisfaction, and these were enshrined in legislation on August 2.

The Outcome

The overhaul of the act was extensive, altering or deleting 31 of the 49 clauses, including removal of the controversial "agency" clauses. It allowed doctors to practise under the plan, or

through the voluntary health agencies, if patient and doctor were members, or to practise outside medicare with patients obtaining reimbursement, and it permitted extra-billing in such instances. In addition, it allowed physicians to work in several community clinics, three of which are still operating.

The changed act became the model for future provincial plans. The only exception was Quebec, where structural changes again led to a doctors' strike. The Canada Health Act of 1982-1983 has changed the original Saskatchewan model to resemble the Quebec plan.

In retrospect, both sides were responsible for the breakdown. Each thought they were defending principles. The government focused on universal coverage and the democratic right of a duly-elected parliamentary body to govern. The college defended the freedom of a self-governing profession and free choice for patients. Excesses, immoderate rhetoric, and imprudent actions of both protagonists escalated the confrontation. With public involvement, the clash seemed inevitable if the act was to be changed from a program of "control" to one of "insurance." Unfortunately, the mistakes made have recently been replicated in other provinces.

Personal Observations

- Universal health care that is administered by a public authority is here to stay. Despite frequent small annoyances, it is popular, and even doctors would rebel if we returned to the format of the 1950s.
- A reduction in benefits or transfer of costs to the user is political suicide, be it utilization fees or co-insurance.
- It is unacceptable to the public to retrench or to remove a social benefit once it is conferred: think of old age pensions.
- The fear that doctors would lose their professional freedom and be conscripted to civil service has not been borne out. Doctors are still free to make medical decisions with their patients without direct interference. Any frustrations or delays do not come from individual application but from the overall paucity of funding, especially to institutions such as hospitals. This is central rationing of economic resources, not intervention in private medical judgments.
- The sacred doctor-patient relationship has been preserved. Ask any family physician or obstetrician.
- Universal programs seem not to have interfered with self-government; our right to license, to set and enforce standards, and to use discipline remains.
- Universal extension of health benefits will continue in those quadrennial auctions known as elections. There is no end to the services that the ingenuity of politicians can create; token premiums will go, and the Canada Health Act has virtually outlawed point-of-service fees or extra billing, by fiscally penalizing provincial treasuries.
- Other forms of organization, delivery and payment of health services are and will be promoted. These include health service organizations (HSO) and community clinics. This wholesome development should not be feared or forced. Doctors should be free to work and be paid in a setting that best suits their social thinking. Medical associations must accept this and work to represent these physicians as faithfully as they represent any other group of members, as long as all conform to the standards set by licensing bodies.
- On introduction of a free universal plan, costs rise steeply in the first few years, accounted for by "unmet needs" and familiarization with how to use the program. In three to five years, increases stabilize at a rate slightly above the cost of living index because of expensive scientific and technical advances in diagnostic and medical therapy, the extension of life expectancy, and the high incidence of illness in the aging population.
- Strikes or withdrawal of services by the health professions are unacceptable to the public. They punish those meant to be served. All health professions should by law be forbidden to strike, in exchange for binding arbitration, which may be applied to specified and vital issues when agreement has not been reached by normal negotiation.

A lot of water has flowed past the bridge of the medicare scare of 1962 and I hope that it has washed away some of the mud of that frightful battle.

Summary

The battle over the introduction of medicare to Saskatchewan in 1962 gives the medical profession important lessons that warrant study today. Although the relations among people, politicians, and the profession are calmer, tensions continue. A mechanism of binding arbitration applied to pre-determined, vital issues must be assured to resolve conflicts between governments and the health professions. Provided such a mechanism is guaranteed, health professions should be forbidden to strike by law.

Sommaire

Le combat livré par l'introduction de l'assurance-santé (Medicare) en Saskatchewan en 1962 apporte à la profession médicale d'importantes leçons qui méritent aujourd'hui d'être étudiées. Même si les relations entre le public, les politiciens et la profession sont plus calmes, les tensions demeurent toujours. Un mécanisme de médiation, liant les parties en cause, appliqué à des problèmes vitaux déterminés à l'avance, doit être prévu pour trouver une solution aux conflits entre les gouvernements et les professions oeuvrant dans le domaine de la santé. Sous condition expresse de la garantie d'un tel mécanisme, les professionnels de la santé devraient, conformément à la loi, se voir refuser de se mettre en grève.

Senator WELLSTONE. For those of you who came today, thank you for hanging in there with us for several hours.

[Whereupon, at 4:37 p.m., the subcommittee was adjourned.]

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